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MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials and students of social problems find it of special value.

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SIDNEY M. JOURARD, PH.D.

Healthy personality and self-disclosure

For a long time, health and well-being have been taken for granted as "givens," and disease has been viewed as the problem for man to solve. Today, however, increasing numbers of scientists have begun to adopt a reverse point of view, regarding disease and trouble as the givens, with specification of positive health and its conditions as the problem to solve. Physical, mental and social health are values representing restrictions on the total variance of being. The scientific problem here consists in arriving at a definition of health, determining its relevant dimensions and then identifying the independent variables of which these are a function.

Scientists, however, are supposed to be hard-boiled, and they insist that phenomena, to be counted "real," must be public. Hence, many behavioral scientists ignore man's self, or soul, since it is essentially a private phenomenon. Others, however, are not so quick to allocate man's self to the limbo of the unimportant, and they insist that we cannot understand man and his lot until we take his self into account.

I probably fall into the camp of those investigators who want to explore health as a positive problem in its own right, and who, further, take man's self seriously—as a reality to be explained and as a variable which produces consequences for weal or woe. This paper gives me an opportunity to explore the connection between positive health and the disclosure of self. Let me commence with some sociological truisms.

Dr. Jourard, an associate research professor in psychology and nursing at the University of Florida College of Nursing, presented this paper November 20, 1958 at a meeting of the North Florida section of the American Personnel and Guidance Association.

Social systems require their members to play certain roles. Unless the roles are adequately played, the social systems will not produce the results for which they have been organized. This flat statement applies to social systems as simple as that provided by an engaged couple and to those as complex as a total nation among nations. Societies have socialization "factories" and "mills"—families and schools—which serve the function of training people to play the age, sex and occupational roles which they shall be obliged to play throughout their life in the social system. Broadly speaking, if a person plays his roles suitably, he can be regarded as a more or less normal personality. Normal personalities, however, are not healthy personalities (Jourard 1958, 16–18).

Healthy personalities are people who play their roles satisfactorily, and at the same time derive personal satisfaction from role enactment; more, they keep growing and they maintain high-level physical wellness (Dunn 1958). It is probably enough, speaking from the standpoint of a stable social system, for people to be normal personalities. But it is possible to be a normal personality and be absolutely miserable. We would count such a normal personality unhealthy. In fact, normality in some social systems—successful acculturation to them—reliably produces ulcers, paranoia, piles or compulsiveness. We also have to regard as unhealthy personalities those people who have never been able to enact the roles that legitimately can be expected from them.

Counselors, guidance workers and psychotherapists are obliged to treat with both patterns of unhealthy personality—those people who have been unable to learn their roles and those who play their roles quite well but suffer the agonies of boredom, frustration, anxiety or stultification. If our clients are to be helped they must change, and change in valued directions. A change in a valued direction may arbitrarily be called growth. We have yet to give explicit statement to these valued directions for growth, though a beginning has been made (Fromm 1947, Jahoda 1958, Jourard 1958, Maslow 1954, Rogers 1954). We who are professionally concerned with the happiness, growth and well-being of our clients may be regarded as professional lovers, not unlike the Cyprian sisterhood. It would be fascinating to pursue this parallel further, but let it suffice for us to be reminded that we do in fact share membership in the oldest profession in the world. Our branches of this oldest profession probably began at the same time that our sisters' branch began, and all branches will continue to flourish so long as they meet the needs of society. We are all concerned with promoting personality health in the people who consult with us.

Now what has all this to do with self-disclosure?

To answer this question, let's tune in on an imaginary interview between a client and his counselor. The client says, "I have never told this to a soul, doctor, but I can't stand my wife, my mother is a nag, my father is a bore, and my boss is an absolutely hateful and despicable tyrant. I have been carrying on an affair for the last ten years with the lady next door and at the same time I am a deacon in the church." The counselor says, showing great understanding and empathy, "Mm-humm!"

If we listened for a long enough period of time we would find that the client talks and talks about himself to this highly sympathetic and empathic listener. At some later time the client may eventually say, "Gosh, you have helped me a lot. I see what I must do and I will go ahead and do it."

Now this talking about oneself to another

person is what I call self-disclosure. It would appear, without assuming anything, that self-disclosure is a factor in the process of effective counseling or psychotherapy. Would it be too arbitrary an assumption to propose that people become clients because they have not disclosed themselves in some optimum degree to the people in their life?

An historical digression: Toward the end of the 19th century Joseph Breuer, a Viennese physician, discovered (probably accidentally) that when his hysterical patients talked about themselves, disclosing not only the verbal content of their memories but also the feelings that they had suppressed at the time of assorted "traumatic" experiences, their hysterical symptoms disappeared. Somewhere along the line Breuer withdrew from a situation which would have made his name identical with that of Freud in history's hall of fame. When Breuer permitted his patients "to be," it scared him, one gathers, because some of his female patients disclosed themselves to be quite sexy, and what was probably worse, they felt quite sexy toward him.

Freud, however, did not flinch. He made the momentous discovery that the neurotic people of his time were struggling like mad to avoid "being," to avoid being known, and in Allport's (1955) terms, to avoid "becoming." He learned that his patients, when they were given the opportunity to "be"—which free association on a couch is nicely designed to do—they would disclose that they had all manner of horrendous thoughts and feelings which they did not even dare disclose to themselves, much less express in the presence of another person. Freud learned to permit his patients to be, through permitting them to disclose themselves utterly to another human. He evidently didn't trust anyone enough to be willing to disclose *himself vis à vis*, so he disclosed himself to himself on paper (Freud 1955) and learned the extent to which he himself was self-alienated.

Roles for people in Victorian days were even more restrictive than they are today, and Freud discovered that when people struggled to avoid being and knowing themselves they got sick. They could only become well, and stay relatively well, when they came to know themselves through self-disclosure to another person. This makes me think of Georg Groddeck's magnifient *Book of the It (Id)* in which, in the guise of letters to a naive young woman, Groddeck shows the contrast between the public self—pretentious role-playing—and the warded off but highly dynamic *id*—which I here very loosely translate as "real self."

Let me at this point draw a distinction between role relationships and interpersonal relationships—a distinction which is often overlooked in the current spate of literature that has to do with human relations. Roles are inescapable. They must be played or else the social system will not work. A role by definition is a repertoire of behavior patterns which must be rattled off in appropriate contexts, and all behavior which is irrelevant to the role must be suppressed. But what we often forget is the fact that it is a person who is playing the role. This person has a self—or, I should say, he *is* a self. All too often the roles that a person plays do not do justice to all of his self. In fact, there may be nowhere that he may just *be* himself. Even more, the person may not *know* his self. He may, in Horney's (1950) terms, be self-alienated.

This fascinating term "self-alienation" means that an individual is estranged from his real self. His real self becomes a stranger, a feared and distrusted stranger. Estrangement—alienation from one's real self—is at the root of the "neurotic personality of our time" so eloquently de-

scribed by Horney (1936). Fromm (1957) referred to the same phenomenon as a socially patterned defect.

Self-alienation is a sickness which is so widely shared that no one recognizes it. We may take it for granted that all the clients we encounter are self-alienated to a greater or lesser extent. If you ask anyone—a client, a patient, or one of the people here—to answer the question, "Who are you?" the answer will generally be, "I am a psychologist, a guidance worker, teacher or what have you." The respondent will probably tell you the name of the role with which he feels most closely identified. As a matter of fact, the respondent spends a greater part of his life trying to discover who he is, and once he has made some such discovery, he spends the rest of his life trying to play the part. Of course, some of the roles—age, sex, family or occupational roles—may be so restrictive that they fit a person in a manner not too different from the girdle of a 200-pound lady who is struggling to look like Brigitte Bardot. There is Faustian drama all about us in this world of role-playing. Everywhere we see people who have sold their souls—their real self, if you wish—in order to be a psychologist, a guidance worker, a nurse, a physician, a this or a that.

Now I have suggested that no social system can exist unless the members play their roles and play them with precision and elegance. But here is an odd observation, and yet one which you can all corroborate just by thinking back over your own experience. It's possible to be involved in a social group, such as a family or a work setting, for years and years, playing one's roles nicely with the other members—and never getting to know the *persons* who are playing the other roles. Roles can be played personally and impersonally, as we are beginning to discover in nursing. A husband can be married to his wife for fifteen years and never come to know her. He knows her as "the wife." This is the paradox of the "lonely crowd" (Riesman 1950). It is the loneliness which people try to counter with "togetherness." But much of today's "togetherness" is like the "parallel play" of 2-year-old children, or like the professors in Stringfellow Barr's novel (1958) who, when together socially, lecture past one another alternately and sometimes simultaneously. There is no real self-to-self or person-to-person meeting in such transactions.

Now what does it mean to know a person, or, more accurately, a person's self? I don't mean anything mysterious by "self." All I mean is the person's subjective side—what he thinks, feels, believes, wants, worries about, his past and so forth—the kind of thing one could never know unless one were told. We get to know the other person's self when he discloses it to us.

Self-disclosure, letting another person know what you think, feel or want, is the most direct means (though not the only means) by which an individual can make himself known to another person. Personality hygienists place great emphasis upon the importance for mental health of what they call "real self being," "self-realization," "discovering oneself" and so on. An operational analysis of what goes on in counseling and therapy shows that the patients and clients discover themselves through self-disclosure to the counselor. They talk, and to their shock and amazement the counselor listens.

I venture to say that there is probably no experience more horrifying and terrifying than that of self-disclosure to "significant others" whose probable reactions are assumed but not known. Hence the phenomenon of "resistance." This is what makes psychotherapy so difficult to take and so difficult to administer. If there is any skill to be learned in the art of counseling

and psychotherapy, it is the art of coping with the terrors which attend self-disclosure, and the art of decoding the language—verbal and non-verbal—in which a person speaks about his inner experience.

Now, what is the connection between self-disclosure and healthy personality? Self-disclosure, or should I say "real" self-disclosure, is both a symptom of personality health (Jourard 1958, 218–21) and at the same time a means of ultimately achieving healthy personality. The discloser of self is an animated "real self be-er." This, of course, takes courage—the "courage to be" (Tillich 1954). I have known people who would rather die than become known, and in fact some did die when it appeared that the chances were great that they would become known. When I say that self-disclosure is a symptom of personality health, what I mean really is that a person who displays many of the other characteristics that betoken healthy personality (Jourard 1958, Maslow 1954) will also display the ability to make himself fully known to at least one other significant human being. When I say that self-disclosure is a means by which one achieves personality health, I mean something like the following: It is not until I *am* my real self and I *act* my real self that my real self is in a position to grow. One's self grows from the consequence of being. People's selves stop growing when they repress them. This growth-arrest in the self is what helps to account for the surprising paradox of finding an infant inside the skin of someone who is playing the role of an adult.

In a fascinating analysis of mental distress, Jurgen Ruesch (1957) describes assorted neurotics, psychotics and psychosomatic patients as persons with selective atrophy and overspecialization in the aspects of communication. I have come to believe that it is not communication *per se* which is fouled up in the mentally ill. Rather, it is a foul-up in the processes of knowing others and of becoming known to others. Neurotic and psychotic symptoms might be viewed as smokescreens interposed between the patient's real self and the gaze of the onlooker. We might call the symptoms devices to avoid becoming known. A new theory of schizophrenia has been proposed by an anonymous former patient (1958) who "was there" and he makes such a point.

Alienation from one's real self not only arrests one's growth as a person; it also tends to make a farce out of one's relationships with people. As the ex-patient mentioned above observed, the crucial break in schizophrenia is with sincerity, not reality (Anonymous, 1958). A self-alienated person—one who does not disclose himself truthfully and fully—can never love another person nor can he be loved by the other person. Effective loving calls for knowledge of the object (Fromm 1956, Jourard 1958). How can I love a person whom I do not know? How can the other person love me if he does not know me?

Hans Selye (1946) proposed and documented the hypothesis that illness as we know it arises in consequence of stress applied to the organism. Now I rather think that unhealthy personality has a similar root cause, and one which is related to Selye's concept of stress. It is this: Every maladjusted person is a person who has not made himself known to another human being, and in consequence does not know himself. Nor can he find himself. More than that, he struggles actively to avoid becoming known by another human being. He works at is ceaselessly, 24 hours daily, and it is work! The fact that resisting becoming known is work offers us a research opening, incidentally (Dittes 1958, Davis and Malmo 1951). I believe that in the effort to avoid becoming known a person

provides for himself a cancerous kind of stress which is subtle and unrecognized but nonetheless effective in producing not only the assorted patterns of unhealthy personality that psychiatry talks about but also the wide array of physical ills that have come to be recognized as the stock in trade of psychosomatic medicine. Stated another way, I believe that other people come to be stressors to an individual in direct proportion to his degree of self-alienation.

If I am struggling to avoid becoming known by other persons then of course I must construct a false public self (Jourard 1958, 301–302). The greater the discrepancy between my unexpurgated real self and the version of myself that I present to others, the more dangerous will other people be for me. If becoming known by another person is a source of danger, then it follows that merely the presence of the other person can serve as a stimulus to evoke anxiety, heightened muscle tension and all the assorted visceral changes which occur when a person is under stress. A beginning already has been made in demonstrating the tension-evoking powers of the other person through the use of such instruments as are employed in the lie detector, the measurement of muscle tensions with electromyographic apparatus and so on (Davis and Malmo 1958, Dittes 1958).

Students of psychosomatic medicine have been intimating something of what I have just finished saying explicitly. They say (Alexander 1950) that ulcer patients, asthmatic patients, patients suffering from colitis, migraine and the like, are chronic repressors of certain needs and emotions, especially hostility and dependency. Now when you repress something, you are not only withholding awareness of this something from yourself; you are also withholding it from the scrutiny of the other person. In fact, the means by which repressions are overcome in the therapeutic situation is through relentless disclosure of self to the therapist. When a patient is finally able to follow the fundamental rule in psychoanalysis and disclose everything which passes through his mind, he is generally shocked and dismayed to observe the breadth, depth, range and diversity of thoughts, memories and emotions which pass out of his "unconscious" into overt disclosure. Incidentally, by the time a person is that free to disclose in the presence of another human being, he has doubtless completed much of his therapeutic sequence.

Self-disclosure, then, appears to be one of the means by which a person engages in that elegant activity that we call real-self-being. But is real-self-being synonomous with healthy personality? Not in and of itself. I would say that real-self-being is a necessary but not a sufficient condition for healthy personality. It is in fact possible for a person to be much "nicer" socially when he is not being his real self than when he is his real self. But an individual's obnoxious and immoral real self can never grow in the direction of greater maturity until the person has become acquainted with it and begins to be it. Real-self-being produces consequences, which in accordance with well-known principles of behavior (Skinner 1953) produce changes in the real self. Thus, there can be no real growth of the self without real-self-being. Full disclosure of the self to at least one other significant human being appears to be one means by which a person discovers not only the breadth and depth of his needs and feelings but also the nature of his own self-affirmed values. There is no conflict between real-self-being and being an ethical or nice person, because for the average member of our society self-owned ethics are generally acquired during the process of growing up. All too often, however, the

self-owned ethics are buried under authoritarian morals (Fromm 1947).

If self-disclosure is one of the means by which healthy personality is both achieved and maintained, we can also note that such activities as loving, psychotherapy, counseling, teaching and nursing all are impossible of achievement without the disclosure of the client. It is through self-disclosure that an individual reveals to himself and to the other party just exactly who, what and where he is. Just as thermometers, sphygmomanometers, etc. disclose information about the real state of the body, self-disclosure reveals the real nature of the soul or self. Such information is vital in order to conduct intelligent evaluations. All I mean by evaluation is comparing how a person is with some concept of optimum. You never really discover how truly sick your psychotherapy patient is until he discloses himself utterly to you. You cannot help your client in vocational guidance until he has disclosed to you something of the impasse in which he finds himself. You cannot love your spouse or your child or your friend unless he has permitted you to know him and to know what he needs to move toward greater health and well-being. Nurses cannot nurse patients in any meaningful way unless they have permitted the patients to disclose their needs, wants, worries, anxieties and doubts. Teachers cannot be very helpful to their students until they have permitted the students to disclose how utterly ignorant and misinformed they are. Teachers cannot even provide helpful information to the students until they have permitted the students to disclose exactly what they are interested in.

I believe we should reserve the term interpersonal relationships to refer to transactions between "I and thou," (Buber 1937), between person and person, not role and role. A truly personal relationship between two people involves disclosure of self, one to the other, in full and spontaneous honesty. The data that we have collected up to the present time (using very primitive data-collecting methods) have showed us some rather interesting phenomena. We found (Jourard and Lasakow 1958), for example, that women consistently are higher self-disclosers than men; they seem to have a greater capacity for establishing person-to-person relationships—interpersonal relationships—than men. This characteristic of women seems to be a socially-patterned phenomenon, which sociologists (Parsons and Bales 1955) refer to as the expressive role of women, in contradistinction to the instrumental role which men universally are obliged to adopt.

Men seem to be much more skilled at impersonal, instrumental role-playing. But public health officials, very concerned about the sex differential in mortality rates, have been wondering what it is about being a man, which makes males die younger than females. Here in Florida, Dr. Sowder, chief of the state health department, has been carrying on a long-term, multifaceted research program which he has termed "Project Fragile Male." Do you suppose that there is any connection whatsoever between the disclosure patterns of men and women and their differential death rates? I have already intimated that withholding self-disclosure seems to impose a certain stress on people. Maybe "being manly," whatever that means, is slow suicide!

I think there is a very general way of stating the relationship between self-disclosure and assorted values such as healthy personality, physical health, group effectiveness, successful marriage, effective teaching, effective nursing, etc. It is this: A person's self is known to be the immediate

determiner of his overt behavior. This is a paraphrase of the phenomenological point of view in psychology (Snygg and Combs 1949). Now if we want to understand anything, explain it, control it or predict it, it is helpful if we have available as much pertinent information as we possibly can. Self-disclosure provides a source of information which is relevant. This information has often been overlooked. Where it has not been overlooked it has often been misinterpreted by observers and practitioners through such devices as projection or attribution. It seems to be difficult for people to accept the fact that they do not know the very person whom they are confronting at any given moment. We all seem to assume that we are expert psychologists and that we know the other person, when in fact we have only constructed a more or less autistic concept of him in our mind.

If we are to learn more about man's self, then we must learn more about self-disclosure—its conditions, dimensions and consequences. Beginning evidence (Rogers 1958) shows that actively accepting, empathic, loving, non-punitive responses—in short, love—provides the optimum conditions under which man will disclose, or expose, his naked, quivering self to our gaze. It follows that if we would be helpful (or should I say human?) that we must grow to loving stature and learn, in Buber's terms, to confirm our fellow man in his very being. Probably this presumes that we must first confirm our own being.

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FALSE SANCTUARY

I built a wall of time embodied stone
Around my yard and in it there was sown
Such flowers as no layman's eyes had seen
Lawns that near surpassed the emerald's green.

I built the house by cautious rule and line
To spaciousness that words could not define
With no thing lacking from its foot to vane
With teak from far ChowWan and rugs from Spain.

But in this beauty there was fallacy
For I had built for but these eyes to see
And yet I added (to complete it all)
A lofty gate and spikes along the wall.

The search had ended. Solitude I'd found at last
And hid the key that locked the gate, to prove it fast.
Before retiring, with complacency
Unto the bed no one could share with me.

With sleep I dreamed but in that dream of storm at sea
A pounding surf of voices taunted: "Find the key!"
Until in fright I woke to fight
To fight the night that covered me.

I searched the room, the hall, the house, the yard.
The flowers by their roots were pulled. I turned the sod,
Until in final desperation at the gate
I cling and watch the masses I had learned to hate.

Ah; but the masses who were "Mass" to me
Are not the same when seen respectively
They live and love and know the God I never knew
And build the world, and fight for it, with better worlds in view.

The steel beneath my hand is cold
As I recall a tale of old
About another God-forsaken wall.
Oh Lord of Jericho, might this one fall?

HUGH ADAMS, M.D.

Psychiatry in a small rural general hospital

In 1955, aided by a generous grant from the Commonwealth Fund, the Mary Imogene Bassett Hospital in Cooperstown, N. Y., activated a department of psychiatry. So far as could be learned from the literature at that time there was limited precedent for establishing a psychiatric practice in a rural community or for establishing psychiatric services in a small general hospital. A few papers about psychiatric practice in small communities had referred to communities of 25,000 to 50,000 people; Cooperstown has 2,500. Bennett, Hargrove and Engle in their book, *The Practice of Psychiatry in General Hospitals* [1] included a foreword by Dr. Blain in which he says that no general hospital should be without a psychiatric service, but most of the book was devoted to descriptions of fairly large services in fairly large hospitals. In the last chapter of this book there is a statement to the effect that small cities can succeed in these efforts too, but the example given is Ogden, Utah, a city of 40,000 which had an ongoing ward of 20 psychiatric beds in a 200-bed general hospital. So, we began more with a wish to provide services than with ideas as to how these services might be provided.

A survey made in 1956 by Bush [2] revealed that 223 general hospitals in this country provided separate beds for psychiatric patients. A total of 581 general

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1 Bennett, Abram Elting, Eugene A. Hargrove and Bernice Engle, *The Practice of Psychiatry in General Hospitals*. Berkeley, University of California Press, 1956.

2 Bush, C. K.. "Growth of General Hospital Care of Psychiatric Patients," *American Journal of Psychiatry*, 113(June 1957), 1059–62.

hospitals reported that they accepted psychiatric patients in other than emergencies, but the report did not state how many of them provided only diagnostic or supportive facilities. The figure of almost 600 general hospitals accepting psychiatric patients looked pretty good until one read further and learned that this was less than 11% of all the general hospitals in the country, and a breakdown of the figures given indicated that those hospitals which did have psychiatric beds each had an average of over 10 beds reserved for psychiatric patients. Again these figures seem to indicate the lack of experience with psychiatric units in the size hospital ordinarily thought of as a community hospital.

I should tell you here a little about the Mary Imogene Bassett Hospital. There are 120 beds, including bassinets, divided into six nursing units, one each for pediatrics and obstetrics, one male and one female ward and two private or semi-private pavilions. At the present time, patients in these four latter units are not segregated at all according to services, although planned expansion may provide for primarily medical or surgical wards. There are about 25 members of the senior staff, all of whom are full-time salaried employees of the hospital with offices in the hospital building. A very active outpatient service is staffed by these same physicians. About 15 house officers are in residence, and the school of nursing of a nearby college uses the hospital as its primary clinical training facility. About 57% of the patients admitted to the hospital (3,716 in 1956) come from the county in which the hospital is located and another 35% come from adjacent counties.

Because of the teaching programs and considerable research activity, maintaining a balanced budget depends somewhat on income from an endowment and special grants to the hospital, but the costs to the patients are about the same as those in other community hospitals in the vicinity.

The psychiatric outpatient work has not been strikingly different from that that might be seen in any private psychiatric practice. During three years about 700 new patients have been seen by the psychiatrist. Ordinarily, at any given time, two or three patients will be working in intensive psychotherapy, being seen three or four times a week over a considerable period of time. Four or five patients are being seen at weekly intervals and 20 or 30 patients are being seen at greater intervals. A psychiatric social worker joined the department after about 18 months, and he too has carried 15 to 20 hours of interview therapy each week.

Working in intensive psychotherapy with patients whom one encounters frequently in the daily life of the village has some complications but usually has not constituted a real obstacle for the well-motivated patient. Similarly, community gossip about who is seeing the psychiatrist has not, patients tell us, been a problem for them. The major difference is that in a sparsely populated area some outpatients travel very considerable distances, often in severe weather. This means that one must be fairly careful in evaluating or uncovering motivation, but the missed and cancelled appointment rate has not been high.

Caring for inpatients has followed less well defined lines. The first decision we had to make regarding inpatients was where to put them. From the outset, the construction and equipping of a psychiatric ward appeared impractical; the small hospital must maintain considerable flexibility, and it is not nearly so easy as in a large hospital to designate a bed as surgical or medical or psychiatric. If a psychiatric ward had been

built along the usual lines, this flexibility would not have been maintained; good public relations does not admit to bringing patients with gall bladder or coronary disease into an environment of locked doors, Chamberline screens and sharp counts. If we were going to have psychiatric patients and preserve conditions that might be found in most community hospitals, we would have to admit them, by and large, without segregation.

At the same time that we were doing this, Castelnuovo-Tedesco[3] was having a similar experience on a women's ward in a military hospital in Alaska, and he has written of some of the advantages of such a practice. He felt that the psychiatric patients and their ward fellows, because of the lack of segregation, tended to accept the psychiatric illnesses more as medical illnesses. We have not usually found this to be the case, and we have not found it especially helpful when it did turn out to be the case. Comparisons between a psychotic episode and a broken leg can be carried just so far before they break down, and an attitude of waiting for time and the doctor to cure the psychiatric illness may sometimes impede the patient's participation in his own healing. Other patients are sharply aware that the psychiatric patients do get up, get dressed, go out for activities, see more of their doctors and generally disport themselves quite unlike usual hospital patients. These differences can sometimes be helpful to the psychiatric patient in an occupational therapy or role-taking kind of way. One schizophrenic girl did begin to regain some feeling of identity in mailing letters and filling water glasses for other patients; another woman with an hysterical character structure and tremendous hunger for love seemed to begin to recover from a panic related to her not being able to gain affection sufficient for her tremendous needs when she became the angel of mercy in the ward.

The policy of admitting psychiatric patients to the medical and surgical wards has, however, been of great usefulness in getting families of patients to accept hospitalization for the patients. The family which has lived with an acutely psychotic patient for a week or two and is guilty about its unconscious wishes to be rid of the patient accepts this easy way out. With some help from the social worker, they seem more readily to accept the fact of the illness without being too separated from the patient. Despite the time-honored practice of sharp restriction of visitors to psychiatric wards, we have really very little evidence that visitors disturb our patients, and we suspect that this notion has taken most of its origin from the fact that visitors disturb hospital routine. Related to admission of patients to general wards is the fact that patients rarely refuse suggested treatments. That the family has been comfortable in visiting the patient in not unfamiliar surroundings has been related to the great ease with which many of our patients have returned to their homes after hospitalizations.

In 1955, when services began, chemical restraint was just coming into its own, but we did not find this adequate help for admitting disturbed patients to the general wards. Something of a prejudice in the psychiatrist against constructing a tight room two or three times almost caused the collapse of the whole program. The 48 hours required to bring the very active patient under the influence of a medication can panic the patients and personnel of a

[3] Castelnuovo-Tedesco, P., "Care of Female Psychiatric Patients, Including the Acutely Disturbed, on an Open Medical and Surgical Ward," *New England Journal of Medicine*, 257(October 17, 1957), 748–52.

ward. Moreover, of course, an episode of excitement may erupt with little previous warning, and a protection for the patient and his ward fellows and his attendants must be immediately available.

There is now one room equipped for handling disturbing patients. Interestingly, the availability of the room has much reassured hospital personnel, and requests that patients be moved to such a facility have decreased, it seems to me, since we have it. We purposely chose quite a large room, about 20 x 20. It is part of a nursing unit, and is regularly used as a 2-bed room when we do not have a disturbed patient in it, again maintaining the flexibility so necessary. We like the fact that it has no bath and patients must be taken out frequently. We like the fact that when the door is opened, the patient is not behind another locked door but is immediately in an environment where some social control is expected.

With this one room, taking all patients that seek admission, and with an average hospital census of around 80 patients, we have not had to ask that a patient be moved to another hospital because we could not handle his behavior. Before equipping this room, we had had to do this several times.

When we began to admit our psychiatric patients, the question of suicidal attempts was, of course, immediately raised. In this particular situation, happily, the hospital administration did not press about this, but the nursing personnel was very uneasy indeed. I shall mention this problem later. We have had only one suicidal attempt, almost surely brought on by the psychiatrist's insensitive response to the request of a schizophrenic man for a razor; there was plenty of evidence to show that he was hallucinating voices which instructed him to kill himself, but he was told that he could have his razor if he wanted it. We continued to work with this man to a social recovery, but he became ill again a year later and finances required his being admitted to a state hospital, from which he has since been discharged.

Private psychiatrists in many places have, of course, been treating depressed patients with electroconvulsive therapy on private pavilions for some years with no rash of suicides, but very little has been said about this in the literature that reaches nurses and doctors. In keeping with the experience of other psychiatrists, these patients have given us little management difficulty. It is our impression that less regression is seen in the depressed patient who is kept off a psychiatric ward. It is our impression that the early improvement in the depressed patient treated with ECT is greater if the patient is kept in an unsegregated group. In this group we do find the comparison to other medical illnesses helpful to the patient in accepting the treatment about which he has heard so many horror stories; it is surprising to see how rapidly patients come to equate their shock therapy with irrigations or thorocenteses or, as one surgical patient asked us who had seen us come onto the ward to do ECT, why did some patients always sleep a while after their EKG's?

It was mentioned above that some of the nursing personnel were uneasy when we began to admit psychiatric patients to their floors, but it is hard to tell you just how uneasy they were. Our own eagerness to reassure them only made matters worse for some time; you can imagine that it helped matters not at all when a night nurse was told that she would be no more responsible if a psychiatric patient committed suicide than if a patient with a peptic ulcer bled to death. Then she knew that the suicide was a certainty.

The magnificient directress of nurses in

our hospital saved the day after several of these near misses. With little help from us, she quietly communicated to her staff that we were going to accept and treat these patients. She did us the kindness of telling us kindly but firmly when one of our patients was overstraining the tolerance of her staff.

With her we worked out what has been the answer to our nursing problems, and it cannot be sufficiently emphasized that a program like this cannot succeed unless such an answer can be found. In the same way that large amounts of space cannot be restricted to the use of one service, so too, but more critically, flexibility in the use of nursing personnel must be maintained. Even if there were funds for it, there would be little chance of getting and keeping psychiatric nurses in a village like ours, and we wouldn't know what to do with them during the times when we have one or no patients. What we did was to take a nurse who had worked for several years in the hospital. She was given head nurse status. Her duties are to take care of psychiatric patients throughout the hospital during the day shift. She assists with treatments. She does morning care for most psychiatric patients, arranges outings for them, escorts them downtown for shopping, and so on. Later a second nurse was brought in and made familiar with our routines. She too was kept on the daytime shift. If we have three patients or less, one of the nurses returns to general floor duty; if we have no psychiatric patients, both nurses do floor duty.

By having two nurses, some provision for week-end coverage can be made, but more importantly, the two nurses have an opportunity to discuss their experiences and keep their anxieties at tolerable levels. Our nurses have been encouraged to take coffee breaks with the other nurses on the floors, to discuss with them what our attitudes and aims are with each patient, to leave quite full nurses' notes so that other nurses can know what is important to us. Also, we have urged them to assist in the nursing care of patients not on the psychiatric service but having periods of emotional storm. Frequently, when psychiatric consultation for a patient on another service has been requested, we have had our nurses do morning care for that patient, and in not a few cases the information they have obtained by taking their time and allowing the patient to talk has obviated the need for the psychiatrist's visit.

Our nurses constitute the most meaningful liaison we have been able to establish with the hospital community, and it is pleasant to be able to acknowledge my debt and gratitude to them. Nursing care during the evening and night is provided by the floor nurses, but it should be emphasized that this has gone far more smoothly since special nurses have worked during the day.

What sort of patients can we care for in this setting now? So far as I know, with the functions mentioned above now established, we do not have to exclude any patient. We aim at being an acute service, and we serve a community in which most of the people could not afford very long stays at $20 per day even if we wanted it otherwise. Moreover, the hospital must meet the medical needs other than psychiatric of the community, and we would not be justified in tying up its beds for the care of chronically ill patients.

Patients in psychotherapy can be cared for during panic states. I have indicated that ECT is administered easily; we have a small cart with the stimulator, a suction machine, a small tank of oxygen with a mask and bag for positive pressure breathing, a laryngoscope and emergency drugs;

pentothal is administered to the patient in his own bed, the cart is rolled in, a seizure-free treatment is administered, and the patient recovers in his bed.

We have one room in the hospital in which we do physical treatments for outpatients, or for inpatients who are apt to recover noisily. We have used this room for the two patients who have been given insulin coma therapy; subcoma insulin is done on the wards. In this same room we do antabuse-alcohol tests, lumbar punctures, Funkenstein tests and the like, and, most importantly, we go there to have a cigarette and talk things over with our nurses. Since the psychiatrist's office is in the hospital building, most psychotherapeutic sessions are conducted there, but under other circumstances such a treatment room could easily have added a couple of chairs for this purpose.

Some of the advantages of such a program have been mentioned or implied; others are obvious. The ease with which patients and families accept hospitalization is quite impressive. Stigmatization is minimal. Although certainly it is sometimes highly therapeutic to allow a patient asylum —and we have several times recommended state hospital care to patients who wanted and could afford our services—we are also convinced that the period of disability for many psychiatric patients requiring hospitalization is decreased by allowing them to remain in familiar hospitals in their own communities. The community hospital is much more likely to be a part of familiar reality and less likely to encourage withdrawal from the healthy pressures to reality-testing which do exist.

The opportunity for non-psychiatric patients to see what happens during psychiatric hospitalization is surely as potent a device for freeing our work from too familiar prejudices and stigmata as most brochures and lectures or television programs, and over a period of time a surprisingly large audience can be so reached. Not the least important members of this audience are our fellow professional workers.

We have done almost no lecturing. We have had no group sessions for nurses. We do have psychiatric rounds once each week in which one patient is discussed, attended mostly by resident and attending physicians and students. But mostly by precept we have been quite successful in disseminating some basic and important facts to non-psychiatric personnel about psychiatric illnesses. It is happy progress that many of the nurses who have gone through this learning process with us accept and work with acute but often very serious psychiatric symptoms occurring in their patients. It is far more than semantic progress that we hear much around the hospital about patients who are hallucinating or illusional or deeply depressed, but we hear very rarely now of patients who are out in left field or flipped or crazy. We get far more requests from nurses for orientation regarding attitudes than for sedative orders. After the first appalled month or so, our house staff asks far more for opinion and help in management than for transfer. Our senior staff seems much less to expect us to take over the lives and all the problems of the patients they refer, but sees us much more as doctors oriented to disease, diagnosing by symptoms, treating from a therapeutic armamentarium far broader than just "taking him off my hands," and aiming at restoration of function.

The psychiatrist too, stripped of the protection of isolation in a segregated ward and associating with physicians who do not speak his jargon, finds that he must reexamine much that is traditional. Differences between physical and psychological diseases do not disappear at all, but the

biological substratum on which they both exist comes much more to the fore. In the privacy of our own councils, we can easily forget that chronic brain syndrome doesn't really mean much in many of its usages, but in talking to a medical house officer one does well to be prepared to discuss why so many of our patients don't show the arteriosclerosis at the autopsy table.

Whether psychiatry and physical medicine are blood sisters, or should be, I will not discuss here. I do know that, actually living in the same house as they must under the circumstances I am describing, they must learn more to speak the same language or else return to their separate quarters. I think my associates have learned a great deal in the last three years about what a psychiatrist—or at least one of them—does and does not do. I know that I have learned a very great deal indeed about what it is like to be a doctor and treat a patient.

There are, of course, disadvantages in this sort of program. The greatest one is professional isolation. The small community may be able to support one but not two psychiatrists. If he is hospitalizing patients, he may find that he has tied himself down severely and that no one is available to provide a continuum in his patients' treatment while he takes vacations or even a weekend. Our specialty is sufficiently non-medical and the personal demands on the psychiatrist functioning as such are sufficiently great that all but the most mature of us need opportunity to talk about our work with professional confreres. Similarly, some decisions that the psychiatrist in a general psychiatric practice must occasionally make have very far-reaching consequences in a patient's life, and having to do this regularly without the benefit of consultation increases the personal strain.

Second, as I have already indicated, at our present state of knowledge I do not think it is wise or sound to go too far in indicating to the patient that his illness is a purely medical one. Third, one disturbed patient in a general medical and surgical ward for even a short period of time can undo a lot of good public relations work. Fourth, while there are advantages in having close contact with nonpsychiatric physicians, a potential disadvantage is that the kind of hospital care we have offered may look too simple to the casual observer, and other physicians not adequately trained may be too much encouraged to proceed with what they call a common-sense psychiatry that is really not based on what scientific foundations we do have. Fifth, such services as these are not intended to provide complete psychiatric care. The general hospital is not the place to care for chronically ill patients. The stimulation of the general hospital may be too much for some acutely ill patients. If one proposes, however, to provide fairly over-all psychiatric care, some of these patients who should be cared for elsewhere will have to be admitted before one knows that they should not have been.

Our therapeutic successes have, I believe, been quite adequate to justify the existence of our program. The total number of patients treated is not great enough to lend itself to statistical analysis. In three years we have admitted 133 patients. We know that 13 of the patients who have been hospitalized in Cooperstown have had further psychiatric hospital care elsewhere, many of these on our specific recommendation. We know that a few patients whom we for one reason or another did not admit have been successfully hospitalized and treated elsewhere. Our aim with our hospitalized patients has been to restore function to the point that the patient can return to his community, so that we also know that we have successfully achieved symptomatic relief for many of our patients without achiev-

ing the basic reorganization for which we might have hoped. This, of course, is the same as is true in the large majority of psychiatric hospitals.

Psychiatric care in general hospitals is expanding and is going to continue to expand. I have not here belabored the obvious justifications for this movement; these have been adequately and repeatedly described elsewhere, but mostly regarding large hospitals. I have attempted to tell you of some of our experiences which indicate that these services can be provided in the small community and in the small hospital, if the psychiatrist is willing to tailor his program to the needs of the specific hospital community in which he wants to practice and live. I know now that we cannot do in Cooperstown what can be done in Ogden, Utah, but I also have learned that what Cooperstown or any other community needs is not necessarily the same as what Ogden, Utah, needs. There are important differences between our hospital and many community hospitals. There are enough similarities that we feel we can say that smaller communities and hospitals not only should, but can, have psychiatric services.

ACKNOWLEDGMENT

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JOSEPH HIRSH

Suicide

Magna civitas, magna solitudo

PART I: DEMOGRAPHY OF SUICIDE

Once every minute, or perhaps even more often, someone in the United States either kills himself or tries to do so. Fifty or sixty times each day, day in and day out, people succeed in these attempts. This means that somewhere between 16,000 and 20,000 people suicide each year. In 1955 the suicide rate was 10.2 per 100,000 population, thus ranking suicide among the leading dozen killers in the United States (see Table 1).

Actually the rate is much higher. A substantial number of deaths due to suicide are not so recorded on death certificates because of religious, social or moral stigma. In this respect suicide shares the dubious honor of secrecy with alcoholism, mental illness and venereal disease. Many deaths of adults due to the ingestion of poisons, particularly when large numbers of barbiturate pills are taken alone or in combination with alcohol, are classified as accidental when in reality they are intentional. Many deaths due to gas poisoning, whether in the garage or over the kitchen range, similarly are listed as accidental when they, too, should fall in the intentional column. To this we can add many more—the slow suicide of chronic alcoholism, the savage suicide of far too many automobile accidents, and, increasingly, the subtle suicide of overdosing with tranquilizers. Together these would raise the total to the much more realistic figure of 50,000 to 60,000 cases per year.

While cases and rates represent the final catastrophe, they tell only part of the story of suicide. The magnitude of this story must be measured also in the *attempts* at suicide made each year. Accurate figures

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TABLE 1

Leading causes of death in the United States; death rates [1] for selected diseases, 1955 [2]

1.	Diseases of the heart	355.8
2.	Malignant neoplasms	146.5
3.	Vascular lesions affecting the central nervous system	106.0
4.	Accidents	56.9
5.	Certain diseases of early infancy	39.0
6.	Influenza and pneumonia except pneumonia of newborn	27.1
7.	Generalized arteriosclerosis	19.8
8.	Diabetes mellitus	15.5
9.	Congenital malformations	12.5
10.	Cirrhosis of the liver	10.2
11.	Suicide	10.2 (16,760 deaths)

[1] Per 100,000 population.

[2] Vital Statistics, Special Reports, National Summaries, Vol. 46, No. 5, May 6, 1957.

TABLE 2

Suicide and self-inflicted injury; mortality rate [1] by sex, age and race, U. S., 1955 [2]

	WHITE AND NON-WHITE		WHITE		NON-WHITE	
AGE GROUPS	*M*	*F*	*M*	*F*	*M*	*F*
All ages	16.0	4.6	17.2	4.9	6.1	1.5
10–14	.4	.2	.4	.2	.2	–
15–19	3.9	1.3	3.9	1.4	3.7	1.0
20–24	8.7	2.6	8.6	2.6	9.2	2.7
25–29	12.2	3.8	12.6	3.6	8.4	3.0
30–34	12.6	5.4	12.8	5.8	10.6	2.6
35–39	15.8	5.4	16.4	5.8	9.4	2.0
40–44	22.0	6.8	23.2	7.4	10.9	1.5
45–49	26.5	9.0	28.3	9.6	9.3	2.8
50–54	33.4	10.1	35.7	10.9	11.7	2.6
55–59	39.0	9.9	41.5	10.7	12.7	1.5
60–64	42.5	9.7	45.0	10.1	12.6	4.0
65–69	44.3	10.2	46.7	10.7	12.2	3.3
70–74	44.8	8.0	47.0	8.3	13.4	3.0
75–79	51.1	8.0	54.2	8.4	12.0	2.0
80–84	55.2	8.1	58.2	8.6	14.6	–
85 and over	56.4	6.6	61.2	7.2	12.5	–

[1] Per 100,000 population.

[2] From *Mortality Rate for Selected Causes, Annual Epidemiological and Vital Statistics.* Geneva, World Health Organization, July 1958.

TABLE 3

Suicides[1] *in selected countries, 15 to 19 years of age, by sex*[2]

COUNTRY	YEARS	MALES	FEMALES
Japan	1951–1953	26.1	18.7
Switzerland	1952–1954	16.9	6.4
Finland	1952–1954	12.3	2.6
German Federal Republic	1952–1954	12.1	6.8
Austria	1952–1954	11.7	8.1
Union South Africa (European population only)	1951–1953	9.7	2.8
Denmark	1952–1954	8.3	5.9
Chile	1950–1951	7.6	4.3
Portugal	1947–1949	6.9	6.0
Australia	1951–1953	6.2	1.9
Sweden	1951–1953	6.0	3.3
New Zealand (without Maoris)	1952–1954	5.2	0.5
France	1952–1954	4.4	2.4
United States	1951–1953	3.9	1.6
Spain	1951–1953	3.8	2.0
Canada	1952–1954	3.8	0.7
Italy	1951–1953	2.9	3.3
England and Wales	1952–1954	2.9	1.1
Netherlands	1952–1954	2.3	0.8
Norway	1952–1954	2.0	1.0
Scotland	1952–1954	1.9	0.4
Ireland	1952–1954	0.6	1.1

[1] Per 100,000 population.

[2] From *Epidemiological and Vital Statistics Report, Mortality from Suicide,* Geneva, World Health Organization, 9 (1956), 243.

here, too, are unavailable but estimates based on hospital and police records indicate that at least 5 and as many as 60 attempts are made for every successful one completed. These attempts—costly, cruel and tragic—are the real measure of the specter of suicide which touches and haunts millions of Americans each year.

The demography of suicide, though it is incomplete, suggests that the act is alien to no single age-group. It occurs occasionally even in the very young—indeed, hardly before life has really begun. In the United States it rises in a steady curve from less than 1 per 100,000 population in the age-group 10–14 to 4 per 100,000 among white males in the late teens (see Table 2). Suicide was the second most frequent cause of death in the Yale University student body from 1925 to 1955 (1). But this situation is by no means unique to New Haven. An earlier report (2) covering the period from

1925 to 1935 listed suicide as the third leading cause of death in a number of colleges throughout the country.

A similarly high rate of suicide for students in the older English universities was recently reported (3). The commonest cause of undergraduate deaths during a 10-year period following World War II was accident, followed closely by suicide. At Oxford, for example, suicide was responsible for 27% of undergraduate deaths, which is estimated to be 11 times that of a similar group in the general population. At Cambridge the rate for white undergraduates, male and female, was 17.8 per 100,000, nearly three times that for the population as a whole of England and Wales.

Startling though they may be, these facts pale before the record of suicides in the young in European and certain Far Eastern countries, notably Japan (see Table 3). In Japan, ironically, the second most frequent cause of deaths after suicide in the age-group 15–24 is accidents.

In the United States the suicide rate rises steadily from its relatively low point in youth to an impressive peak of over 50 per 100,000 population in age-groups over 75. Data from current studies in the city of New York bear this out (see Chart 1).

CHART 1

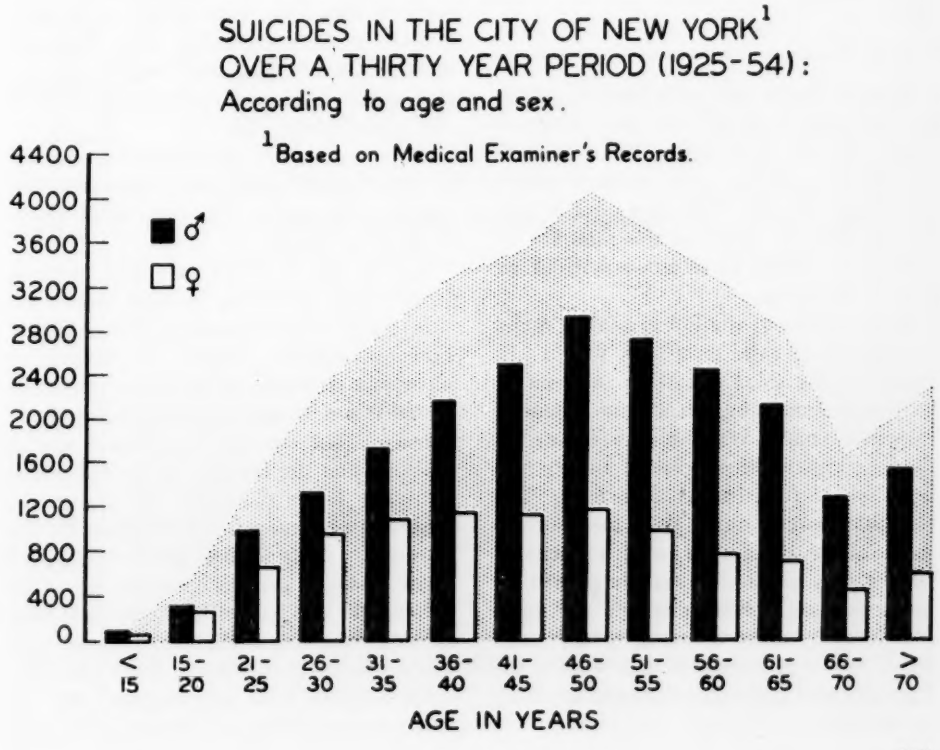


TABLE 4

Ratio of male:female suicides in certain selected countries, 1901 and 1954

		1901	1954
Predominantly Catholic	France	–	3.5:1
	Ireland	4:1	3.5:1
	Italy	4:1	3:1
	Portugal	2:1	3:1
	Spain	4:1	4:1
Predominantly Protestant	Germany	4:1	2:1
	Netherlands	3:1	2:1
	Norway	6:1	5:1
	United Kingdom	3:1	1.5:1
	U. S. A.	3:1	4:1
Buddhist	Japan	1.5:1	1.5:1

Here at home the male:female suicide ratio is approximately 4:1 but is much higher at the older ages. While similar male:female suicide ratios occur in many other countries (see Table 4) it must be said to their dubious credit in this macabre regard that women make more suicidal attempts than men.

Explanations of the differential in male:female suicide rates have been sought primarily in the stress situations inherent in the more demanding social and economic roles of the male. Without underestimating these factors, another possible answer may be in sex-specific patterns of suiciding. The fact that fewer women than men successfully suicide, despite far more frequent attempts, may be found at least in part in the methods used. Men tend to use more precipitous, more action-involved, more lethal agents and methods than women (see Part 2 of this study: Methods and Fashions of Suicide).

In those societies where women have status and role positions inferior to those of men, female suicide rates are generally high primarily because theirs is a hard, unrewarding and often intolerable lot. This is particularly notable in Far Eastern countries and certain agricultural countries in Europe.

With increasing industrialization came increasing emanicipation of women and improvements both in their role and status. With these changes, in Europe particularly, successful suiciding in women became far less frequent than among their male counterparts.

From the stressful factors associated with male suicides it may be conjectured that as women become still more emancipated, increasingly independent and inevitably competitive with men, their suicide rates may become more comparable with those of men, whose suiciding often reflects frustration or failure in achievement, reduction or loss in status and role.

There is a similar racial ratio for suicides. In the United States the white:non-white suicide ratio is 4:1. The ratio of whites to Negroes is 3:1 (4).

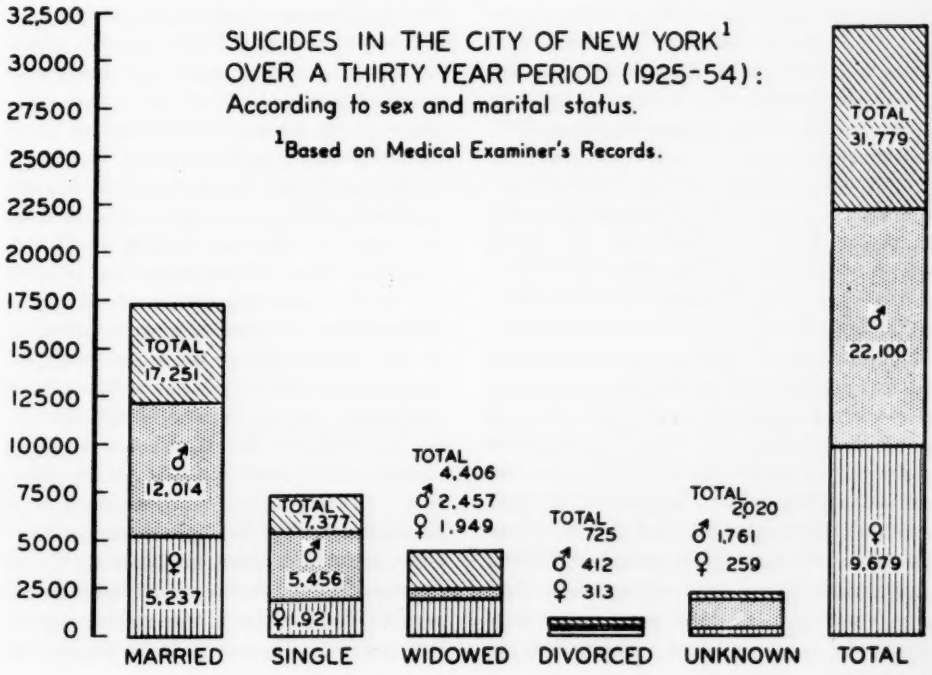
For all that its critics may direct against it, marriage, according to most reports on this subject, neither predisposes to, nor precipitates, suicide. Rather, in tending to encourage externalization rather than internalization of aggressions it may motivate homicide but not suicide! These studies indicate that the rate for married people is generally lower than that for the single, widowed or divorced. It is highest for the divorced. It is higher for the widowed than for single persons up to the age of 35. Thereafter the pattern reverses itself, suggesting that older widowed persons have set up in their children, friends and relatives a network of relationships, like the compensatory collateral circulation in coro-

nary disease, which makes life possible. The single person in the older years—to extend this analogy one more step—like the uncompensated diseased heart, is often hopelessly and tragically alone, and it is the tragedy of this aloneness which perhaps more than any other single factor predisposes to suicide.

Sainsbury in his study of suicide in London (5) and the author in his current series of studies of suicide in New York (6, 7, 8) presently offer a minority view that the suicide rate among the married is not quite so low as has been reported previously (see Chart 2). It may be that these data are skewed largely because of the age factor. With their further elaboration, which is currently in process, it may be that these rates for married people will assume the position more generally reported.

When what the social scientists call the relational systems generally are weakened or if they have not been established or strengthened the suicide rate tends to rise. This principle expresses itself in another dimension. In cities where there is a relative lack of meaningful human contacts and relationships—as compared with rural areas where ties of family, friends and church are so much stronger—suicide rates are higher. In fact, it may be said that urbanization seems to be a factor in suicide. The city confers anonymity and freedom from controls. An individual's status is reflected largely and too often by what he owns, not who he is.

CHART 2



The extent to which city life, with its lack of internal restraints and its weakened relational systems, tends to encourage all sorts of antisocial action has been reported in a series of sociological and psychological studies over the last quarter of a century. Shaw and his associates (9), in a study of delinquency in Chicago, found that delinquency increased with poverty and, to take one economic factor alone, diminished with home ownership. The broad conclusion they drew was that communities by and large had a direct, causal relationship to delinquency. Poor neighborhoods generally have an active criminal tradition, and as such tend to foster delinquency. This point of view was confirmed by Burt (10) in his study of the problem of delinquency in London.

Faris and Dunham (11) in their study of the ecology of mental disorder in Chicago found the lowest rates in neighborhoods of greatest social stability and the highest rates in rooming house districts, slums and other areas inhabited by those generally underprivileged groups—the foreign born, Negroes and transients. In general, these findings have been corroborated by Schroeder (12) in his study of Peoria. To be sure, there have been criticisms of the putative cause-and-effect relationships of these studies, the central one of which is that low status neighborhoods tend to attract antisocial and mentally disturbed individuals, not necessarily to create them. These criticisms notwithstanding, there are sufficiently provocative aspects to these data to give pause for thought not only in their own right but as they have some relevance for the ecology of suicide. Cavan's (4) study of suicide in Chicago indicated that the communities with the highest rates had shifting populations living in rooming houses and cheap hotels. Restless, impersonal, rundown or impoverished neighborhoods, whether they are causally responsible for them or not, harbor people who have higher rates of divorce, alcoholism, drug addiction and suicide. These findings have been confirmed by other investigators, notably Schmid (13, 14, 15) in Minneapolis and Seattle, Faris (16) in Providence and Sainsbury (5) in London.

These various studies may be summarized by the statistical observation that suicide rates fall steadily from a high point in cities of over 100,000 to a low point in rural areas.

The city is only one of many relational systems bearing upon suicide. Economic and occupational status are two other prominent ones. Statistician Dublin (17), sociologist Gillin (18) and psychiatrist Sainsbury (5) independently arrived at the same conclusions for suicide—namely, that the rates are highest in the higher and lower occupational status groups and lowest in the middle occupational status groups.

Thus, one might infer that wealth at one end of the economic scale and poverty at the other predispose to suicide. This, however, has not been supported by the many studies of attempted suicides. Rather, it has been suggested by the second principle of Sainsbury (5), adducing from these studies, that mobility—not only spatially but also upwards or downwards from class to class or from occupation to occupation—and subsequent isolation from, or cohesion in, the community are far more significant factors in causality. He has deduced "that indigenous poverty does not foster suicide. On the contrary, the suicide rate tends to increase with social status. On the other hand, poverty befalling those used to a better standard of living is a burden badly tolerated, and a factor predisposing to suicide, secondary poverty of this kind would account for the rise in the suicide rate in the upper occupational classes during the

economic depression . . . , and the discrepant finding that the incidence of suicides living in poverty is greater when the suicide's actual economic level at the time of death is the criterion, rather than the economic status that might be inferred from occupation and neighborhood."

Serious physical illness is often another factor associated with suicides. Cavan (4), Andics (19) and others have reported a range of incidences of illness in suicides. But the extent to which these are contributory to the suiciding process has yet to be accurately ascertained. Illness itself is tolerable, apparently, judging primarily from studies of attempted suicide. Its effects—incapacitation, separation from the community and loss of work—are what make illness appear to be intolerable and hence causal in the suicide. Thus it may be that pain from neoplastic disease, for example, may be far less of a precipitant to suicide than the isolating effect of the disease—the disability and the separation from the family through hospitalization.

A number of psychiatric studies similarly point up the fact that suicides are generally disturbed persons. Despite the composite picture of the attempted suicide as an immature, egocentric, solitary individual, apparently unable to establish or maintain meaningful relationships and burdened with aggressive behavior which, when not externalized, tends to be turned inwardly, mental illness as a *sine qua non* to suicide is a sheer pat-ism. Many workers, whatever their discipline orientation, feel that much more work has to be done before a direct causal relationship of mental disorder to suicide can be established.

The meaning of relational systems may be seen also with reference to religion. The notion is generally held that religion serves as a prophylaxis against suicide. The more formal and binding the religious ties and practices the less likely, is the belief, that its faithful will ever commit suicide. Under these circumstances one would expect that Catholics would have the lowest suicide rates and Unitarians, Reformed Jews and Ethical Culturists the highest. The one with its strict canons imposes severe injunctions and penalties against this most mortal of sins; the others are far less doctrinaire on this form of *exitus*. Actually, many predominantly Catholic countries have had a consistently low suicide rate with little change over the last fifty years. Yet Spain, during this same period, has tripled its suicide rate. It would be interesting to know the suicide record of Israel since its founding, where strong group identity, an anti-suicide factor in itself, is found in combination with relative freedom from orthodoxy. But even in the absence of such information it appears that Jews tend to be low man on the totem pole of suicide. It may be that their centuries-old struggle for individual and collective survival has made unnecessary formal prohibitions against suicide.

Business cycles, wars, the moon and scores of other factors have been casually or systematically studied in relationship to suicide. But none has quite the fascination or potentially has as significant meaning as has weather in relationship to suicide.

Throughout history, weather, as weather, has been associated with states of physical and emotional well-being. In the temperate zone, the sunny, cloudless, brisk, relatively humidity-free day generally activates the sparkle in people. The dull grayness of fall and winter days, contrariwise, has a characteristically depressing effect. In the tropics the insistent monotony of cloudless days and searing sun have been known to wear some people into a state of lethargy and hopelessness and agitate others to the point of mania.

Alterations in bodily state, ranging from mild discomfiture and indisposition to frank disease, have been observed during changes in weather conditions. Colds and other upper respiratory complaints, aching rheumatic joints, nagging scars from operations or old wounds and amputation stumps are concomitants of the falling barometer. The *chamsins,* those hot, east, sand-laden desert winds of the Arabs which blow out of North Africa and the Middle East, and the *siroccos* and *mistrals* blowing across the Mediterranean into France and Italy not only dry out the nasopharynx and irritate the conjunctiva, thereby setting the stage for upper respiratory and eye infections, but with their unremitting quality create serious disturbances of mood and outlook in many people, healthy or emotionally disquieted.

It was not only the searing sun but the violent *mistrals* of the Midi which drove an already tortured Van Gogh to his death. Switzerland, too, has its particular wind, the *Föhn,* which, unlike the sirocco, is hot and humid, gathering moisture as it crosses the Alps from Italy. An increase in crimes of all sorts—homicides in particular and suicides—follows in its wake. The courts in Switzerland and Germany take this into account in dealing with cases associated with this wind. In our own west (Colorado) there is a wind much like the *Föhn,* called the chinook by the Indians.

"Shifts in weather are often accompanied with marked changes in mood. With the pressure falling and the temperature rising many people are afflicted with a feeling of futility," according to one expert. "In children this takes the form of increased irritability, a restlessness and petulance. . . . Adults . . . are also more quarrelsome and fault-finding, with a tendency to a pessimistic viewpoint toward all matters. . . ." (20). Take then on such days the child in his agitation and the *vieux* in his depression, the one spurred by spite, tortured by guilt, overcome by loss, the other hopelessly lost in his aloneness, living out as he sees his final days without meaning, warmth or purpose—and it is understandable that suicide rates should be distinctly higher then than at other times.

Considered by themselves these demographic data are statistical entities and oddities. At best they are only clues to suicide. But in their dynamic interrelationships they take on a meaning in depth, as we shall see in due course.

ACKNOWLEDGEMENT

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MORRIS WEINSTEIN, ED.D.
F. D. McCANDLESS, M.D.

Empathic communication and anxiety in medical students

A current phase of medical education concerns the attempt to provide a type of training that will sensitize the medical student to the "humanistic" elements in the doctor-patient relationship. Increasing emphasis is being placed upon those issues, other than diagnosis and treatment, which are important in maintaining a sound relationship with the patient.

This report is part of a program aimed at an evaluation of a comprehensive family care program on affective aspects of student growth (1, 2, 3). Three areas of student involvement are under study: the degree of empathic communication, the degree of anxiety about illness, and the degree of adequacy, as these relate to medical care.

Two suppositions are being investigated. The first is that professional empathic communication is a function of personality and is not particularly influenced by medical school curricula. Thus there should not be differences in this area between first-year and third-year students nor should there be differences between third-year students exposed to differing curricula.

The second hypothesis is that anxiety in a student's perception of illness is influenced by the extent of his medical knowledge, and also that the student's concept of his adequacy in the sickroom is a function of time spent in medical school.

PROCEDURE

The population studied consisted of an entire freshman class, comprising 64 students, and a third-year class of 50 students. All subjects were evaluated by projective

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techniques at the beginning and at the close of the school year, a period of eight months elapsing.

The freshmen took the usual preclinical courses. This group was included as a baseline of comparison against the more advanced students. If attitudes are due to personality primarily then there should be no significant difference between groups. The third-year students were divided into a control and experimental group. Experimental subjects were selected on the basis of stratified random sampling. Stratification was made according to grade point average achieved during the first two years of medical school. This was done so that differences related to scholastic achievement would be eliminated. The control group was exposed to the conventional third-year curriculum, which at this school is primarily centered on clerkships in the outpatient department. The experimental group was exposed to the same curriculum. In addition, they participated in the comprehensive family care program, which was substituted for a 66-hour course in public health.

Each experimental student was assigned the role of family physician to one family for a 9-month period. Duties were those of a general practitioner and included home visits, conferences with community agencies, and individual meetings with the family care staff. Students also participated with the staff bi-weekly in small student-oriented seminars. The family care staff was comprised of the chairman of the department of community health, who acted as group leader and coordinator of the project, an internist, a social worker, a public health nurse, a pediatrician, a psychiatrist and a psychologist.

METHOD OF EVALUATION

Several projective tests are being evolved in this program as a means of exploring relevant attitudes. The findings reported here are derived from the sickroom situation test, an experimental procedure which is still in preliminary form. It is based upon a semistructured thematic apperception projective technique. This test comprises a slide of a sickroom with a doctor talking to a mother, and a multiple-choice response sheet. After instructions have been given, the picture is flashed on a screen and the students are told to select from multiple-choice items those which they consider best describes what is happening in the picture.[1]

Interpretation of responses is made on the basis of weighted scores. Responses are graded so that findings will be objective, and quantitative analysis can then be carried out. There are four major response categories: Empathic communication, anxiety, adequacy and the over-all self-concept regarding the sickroom situation. Briefly, the rationale is:

Empathic Communication: Empathy is defined as "mental entering into the feeling or spirit of a person; appreciative perception or understanding." Empathy score is determined by relating the degree of coincidence between the student's concept of how the mother feels and the issue with which the doctor is concerned. For example, a highly empathic score would be obtained by the student who sees the mother as "worried about her adequacy in following instructions" and the physician as perceiving that "the mother's anxiety hampers understanding of doctor's instructions." An unempathic score would be obtained if the student seeing the same concern in the mother perceived the doctor as preoccupied with "the correctness of his diagnosis."

[1] McCandless, F. D. and M. Weinstein, "Relation of Student Attitude Changes to Teaching Techniques," *Journal of Medical Education*, 31(1956), 47.

Anxiety: Experienced physicians perceived most illnesses in this picture as of a minor nature and something easy to handle, rather than as emergent problems of life or death. Therefore, it is postulated that the gravity with which illness is apperceived in the picture is a function of his inexperience and/or apprehension.

Adequacy is scored on the basis of what the student sees the doctor doing after handling the medical problem.

The Gestalt score comprises the total of all the sub-scores and is therefore a composite of over-all perception of the sickroom situation.

VALIDITY

The intangibility of the emotional factors being explored has necessitated validation through the use of clinical appraisal of subjects by several experienced judges. Six judges—members of the departments of psychiatry and pediatrics of the medical college—were used. They were asked to observe several groups of students rotating through the departments and to evaluate them in specific areas.

Twenty-three students were randomly selected during a 6-month period. The students were tested at the termination of their assignment. The consensus of the judges for each student was then compared with the test scores. Correlation between judges' opinions and students response in the three test areas are significant on the 2% level or below when Yates correction is applied. Further extensive validation is of course necessary.

RESULTS

At the outset, the family care, the regular curriculum and the freshman groups were similar in all the subtest areas but one. This exception was in the gravity or anxiety with which the illness situation was approached. Here the freshman (baseline) group was significantly more anxious than the third-year group.

The freshman *Gestalt* score is no different before and after the first-year experience; patient-oriented perceptions have not changed. The primary characteristic of this group is that these students are not involved in clinical work and do not come into contacts with patients. The functions measured on the test therefore do not change appreciably as a result of the first year in this medical school curriculum. Neither do the control students improve significantly on the basis of their hospital work. This is in contrast to the growth reflected in the *Gestalt* score of those students who have had, in addition, the family care experience.

When the three groups are compared at the conclusion of the school year, there becomes apparent a noteworthy shift in the empathy area. The level of first- and third-year groups is similar at the outset and also at the end of the year in empathic communications. When the family care group is compared with the others, however, it is found that there is an increase in empathy in the family care group and a decrease in the control group. The difference between them is significant at the 5% level. The freshmen do not fluctuate significantly, although they do manifest some slight decrease in empathy. Thus in the third year the family care students evidenced an increased ability for empathic communication while the control students declined in this respect (Table 1).

In the area of anxiety, as measured by the illness choice, the family care and control groups showed no significant difference at the outset or at the end of the experimental period. However, the difference between freshmen and juniors became even greater

TABLE 1

Comparison of means in all groups: after

AREA	TOTAL THIRD YEAR	FIRST YEAR	SIGNIF.	FAMILY CARE	CONTROL	T = .05 SIGNIF.
Anxiety	2.78	3.35	S	2.75	2.74	NS
Empathy	2.75	2.90	NS	2.00	3.20	S*
Resolution	0.51	0.50	NS	0.60	0.45	NS
Consistency	1.20	1.30	NS	1.10	1.26	NS
Adequacy	1.32	1.70	S	1.25	1.36	NS
Gestalt	8.58	9.68	S	7.55	9.27	S**

* Family care also significantly more favorable than first year.

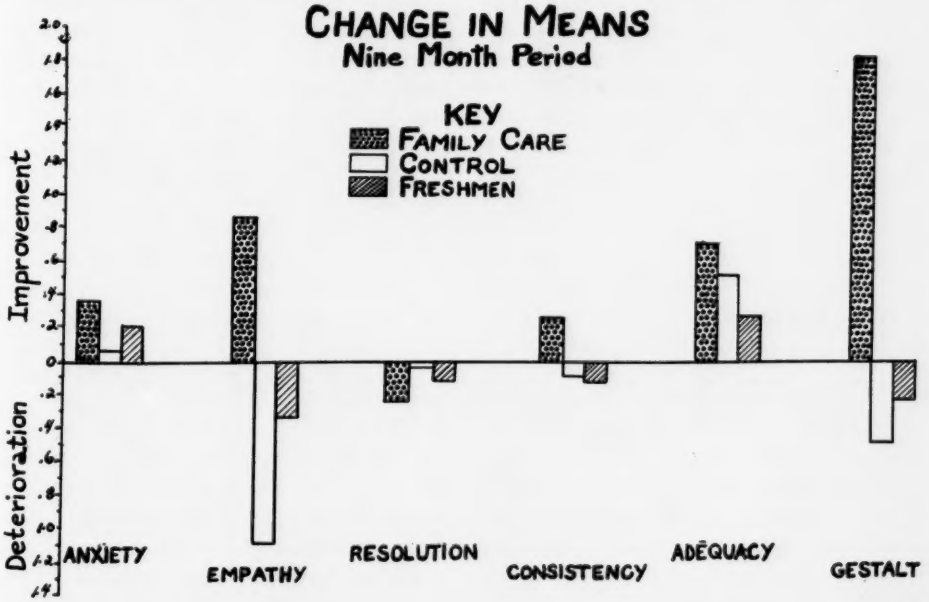
** It is noteworthy that the gap between family care and control has widened not only because family care is more favorable, but because control has declined to a less empathic trend.

at the end of the year. This would indicate that the gap between freshmen and third-year students is ascribable to factors other than chance and is probably a function of clinical experience common to both experimental and standard curriculum.

In the area of adequacy the family care and control groups are similar to the fresh-

TABLE 2

Changes in mean value of test responses for all groups over a 9-month period



men at the outset. At the end of the year the freshmen remain the same and both third-year groups have improved significantly from their original level (Table 1).

The degree and direction of the changes in all areas for the three groups are summarized in Table 2. It should be pointed out that the difference in empathic communication is due to improvement in the family care students as well as a decline in this function in the other groups. The marked gain in the *Gestalt* score of the experimental group reflects not only the significant improvement in empathy scores but also minor trends that, taken alone, are not significant. Thus there may be greater intangible benefits than are apparent from isolated factor scores.

DISCUSSION

The null hypothesis was predicated on the concept that empathic communication is essentially a function of personality not appreciably influenced by medical school training. The findings indicate that first- and third-year students do indeed generally share similar concepts of empathic communication. However, there was a significant difference in the responses of the experimental group as compared to those of all other students at the conclusion of the year's experience. Although the variables of both close longitudinal doctor-patient relationship and student-oriented conferences differentiated the experimental curriculum, it is outside the scope of this study to evaluate the exact contributions of each.

As Table 2 indicates, the gain by family care is significant only because there is an increase in empathic communication in this group and a decline in the controls. By themselves these changes are not significant, but when both divergent trends are considered the difference becomes noteworthy. It is interesting that the negative change in the controls represents a downward trend in this conventional third-year group. This tendency seems to be in keeping with Eron's findings (4) in which he noted that there is an increase in "cynicism" and a decrease in "humanitarianism" among upper-classmen when first- and fourth-year medical students are compared. The experiences gained in this type of experimental program may stem a "negative" tendency developing in the third year, even increasing empathic communication slightly, whereas students in the conventional curriculum gravitate to a slightly less empathic position. In any event, much more remains to be investigated along this line.

The second hypothesis is borne out in that there is a correlation between time spent in medical school and perception of illness. Increasing experience, as might be expected, seems to reduce the apprehension or grimness with which the sickroom situation is viewed.

Adequacy, as evaluated by this method, is contingent upon the degree of independence of the student in solving medical problems. (This is probably an oversimplification.) The less "adequate" student sees himself as seeking authoritative support. It is interesting that at the outset there was no difference between students just entering medical school and those who had completed two preclinical years of basic science in medical school. However, after a year of rotation in the clinical departments, both of the third-year groups became significantly more adequate or independent than the freshman group.

The *Gestalt* or total pattern of affective areas started from the same baseline; except that by chance the experimental family care group was at a slight disadvantage. After participation in the family care program these students manifested a significant posi-

tive shift in over-all development of the affective areas measured. This trend differentiated the family care students from those in the first-year and in the conventional third-year curriculum as well.

It should be kept in mind that the sickroom situation test is still in a preliminary experimental version and requires further validation and refinement. Another consideration is that the sample is not only a small one, consisting of one group in each category, but is limited to this medical school and to a specific curriculum exposure. Although results cannot be generalized to other schools, preliminary evidence does indicate that affective aspects of the doctor-patient relationship can probably be influenced by involvement in a carefully structured setting. It is noteworthy that although the use of empathy was never mentioned as such by the staff, the most marked change in the experimental group occurred in the conative area of empathic communication.

There are also implications here for research in other professions, particularly those relying essentially upon an interpersonal approach. While technical competency can be reasonably assumed and assessed when a training program is completed, there is certainly a wide range in the quality of empathic communication among professionals in the behavioral sciences. If curricula were formulated with a view to developing even greater skill in professional empathic communication it would be an invaluable aid, not only in dealing perceptively with clients, but also in providing more satisfaction for the worker. These areas include not only social work, where much emphasis already is placed upon professional interpersonal transactions, but also the behavioral sciences both inside and outside the health professions.

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1. This study is under the general direction of J. Garth Johnson, professor of community health and coordinator of the comprehensive family care program, Albany Medical College, Union University. The total evaluation study includes the analysis both of specially designed projective tests and of small group conferences. Financial support has been through a grant from the Kellogg Foundation.

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CORNELIUS BEUKENKAMP, JR., M.D.

Anxiety activated by the idea of marriage as observed in group psychotherapy

In America, the median age level for first marriages has been lowering steadily. For example, in 1940 the figure for males was 24.3 years, compared to 1955 when the figure was 22.7 years. In the case of females, the 1940 figure was 21.5 years, compared to 20.2 years in 1955.[1] The sociological significance of this tendency has made intensive group psychotherapy a valuable if not critical psychological treatment.

Apparently the long engagement periods that were once characteristic of our American culture have disappeared. In fact, many young people find themselves having to adjust to and decide upon problems which have lifelong consequences frequently in an interval of but a few weeks. As a result of this tendency for persons to marry at earlier ages, coupled with their strong natural gregarious drives, many of these individuals become particularly suited, and even eager, to face their various dilemmas through the framework of group psychotherapy. The goal of such therapy is not to interfere with the early rate of marriage, but rather to enable these young people to marry with deeper convictions, greater satisfactions and freedom from panic.

This placing together of males and females who are in their early twenties into groups of eight in which the stress is upon intensive interpersonal communications quickly and with candor reveals the psychological nature of their common problem—emotional loneliness. For example, upon entering a group and despite their social-

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[1] U. S. Bureau of the Census, 1957.

minded ways, they soon evidence the fear of maintaining a close continuous emotional relationship. They begin to see that their getting together with others, though their contacts may have been often and numerous, have not been truly intimate and therefore have lacked deep emotional gratification.

The initial anxieties expressed about the working of the group often indicated that as individuals they did not feel secure or capable of handling themselves in situations requiring emotional negotiations. From this point in their treatment the feelings of personal unworthiness and the dread of self-exposure came to the surface when they discovered their fellow patients were similarly troubled. After this enlightenment they could then deal with their long-harbored fears and fantasies involving aggressive socially unacceptable attitudes. Such discussions brought forth a resolution—that their fears were based upon their lack of appreciation of the human equation. This was a result of not having been able to accept their normal animalistic cravings in a manner that they felt would be accepted culturally. In other words, these young adults had to outgrow the childish concept that sees life in terms of good and bad. And apparently through the mutual reinforcement that group psychotherapy affords, they could then accept the normality of these needs, free of guilt. These self-derived conclusions were supported by the group leader through emphasizing that human beings could live with their emotions without concealment and control if there was an integration of the emotions and the intellect. And, too, he would point out that all people at some time in their lives are torn between the wishes for sensual satisfaction and the demands of genteel behavior.

At this juncture of their treatment these young people were able to let down more of their defenses. This was demonstrated by talking openly about whether or not they were actually in love and their doubts about their ability to love. Involved in these discussions was the conflict over the intolerance of their mates-to-be because of their shortcomings. The realization of the extent of this conflict had occurred when again experiencing this emotional dichotomy in the group. That is, their need for group harmony and function became jeopardized by their intense, critical, rejective hostilities toward particular individuals in the group.

This ambivalence produced another situation. Mainly, the threatened members, after becoming involved in several major head-on clashes with the group, began to feel secure enough to see that they had been struggling against a loss of personal identity. And they saw this as a parallel response to their impending marriages. Unknowingly, they had felt that marriage was an encroachment upon their identity. During this stage of their group growth this insecurity was expressed often by the individual participant as a fear that he would not be able to be "one of two," but rather that by some ill-defined process in his mind he might become only a part of an unhealthy "oneness."

With respect to the therapist's management, it was found to be more effective therapy not to place individuals who were romantically involved with one another in the same group. In practice, this proved to delay the emergence and resolution of the unhealthy "oneness."

The anxiety of losing personal identification was also expressed through the fear of infertility and of impotency. These qualms then led the focus of their discussions to the subject of heterosexual behavior. The females voiced their immature preoccupation with morality. In lieu of a sense of self-acceptance, they prepossessed themselves

with the subject of their worthiness as they related it to their need of virginity. On the other hand, the males in the group, in the same self-punitive attitude illustrating their lack of a greater perspective of human nature, spoke about their overconcern with sexual self-gratification.

Often in this orientation of self-flagellation, both sexes discussed masturbation. This stimulated a full conflagration. When the major portion of the embarrassment and self-deprecation subsided, they were then able to turn their interest to the more topical problems associated with marriage.

Among the uncertainties were their financial dependence upon their parents, since this too had a defeating influence upon their own healthy self-imagery. In some cases, where marriage meant leaving physically or mentally incapacitated relatives who were dependent upon them both emotionally and financially, feelings of self-worthiness were also attacked.

On the other hand, there was the manipulative use of marriage for raising one's self-status. Such people came to realize that their haste to wed was predicated upon a short-circuited approach to maturity. Upon exploration with these people who were in a hurry to get married, it was interesting to see how this erroneous attempt to obtain maturity was implanted by their parents and to some degree by society as a whole. With the realization that they were using marriage as a stepping stone to maturity, the neurotic need of approval from their parents and society, as well as from their prospective in-laws, abated. Until this realization, they had distorted the influence of their prospective in-laws to such an extent that they were unable to cope with these new relationships. This was true whether or not the prospective in-laws' behavior had been sound. As a matter of fact, it was found that many of these young people felt selfish because they believed they were depriving their prospective in-law families of a love object. Thus, this too had an influence upon lowering their feelings of self-worthiness. And as a reaction-formation they expressed the fear of being "controlled" by their prospective in-laws. It was after the eruption of this identical attitude toward some of the group members that they were able to recognize this mechanism of defense and, more importantly, cease using it.

Another large area of interest troubling these young people was indicated by the males' confusion about their need for multiple sexual partners. At first, and with much rationalizing, the group discussions centered around their "freedom." But under scrutiny the rationalizing failed to hold back their apprehension and was finally expressed in the form of a question: "Why are we not able to live like others by being satisfied with one woman?" Following a short jesting period, which was an unconscious attempt to release the tension, the real issue would prevail. They questioned their masculine endowment and speculated about the causes underlying their deficiencies as males. There were whispers of trepidation that perhaps behind these multiple sexual pursuits there was a homosexual latency. In others, this inability to stay and be close to one sexual partner would arouse feelings that they were deficient in the depth feelings required for love.

In these discussions, where the males would dominate the interaction, again the subject of masturbation would arise. Here the greatest number of sexual misconceptions and distorted viewpoints would reveal themselves. The fear and threat of possible insanity was a common worry. Some would discuss their masturbation as a form of compromise; by masturbating instead of exposing themselves to the pursuit of multiple

sexual partners they saw themselves capable of maintaining their self-imagery and remaining within the interpersonal socially accepted pattern. In this way they felt they could engage in masturbation without the fear of punishment, while at the same time be relieved of their need to sexually pursue a series of women that might bring strong social censorship upon them.

Commonly, following this degree of progress in the battle of liberation from premarital panic, the next hurdle encountered was the idealism of mothers and its antithesis—prostitution. It was here that perhaps the basic conflict behind all these feelings of unworthiness, as they related to their confused sexual fantasies and behavior, became evident. The usual behavioral pattern revealed that the males had strong sensual satisfaction only with women whom they evaluated as unacceptable marital partners. It was with these women that they were most potent and free. Whereas, when they talked about the girls whom they respected or worshipped, inevitably the girls were the type who would meet the acceptable standards for women set up by their mothers. Underneath all the turmoil lay the cogent fact that they were convinced an ideal girl would reject them because of their lustful interests. Therefore, they had to suppress their lust in their relationships with these girls. And thus, with the proximity of marriage, they would be in serious conflict, since they had divided women into two kinds: nice girls like mother and sister, who were unapproachable, and loose women whom they thought of as prostitutes.

Because the groups were mixed with respect to the sexes, the males' distorted concept of the "nice girl" and the "sexually free girl" was more easily resolved.[2] For after listening to how these males were caught in the web of their dilemma, the females of the group were mobilized into action. And since the males held these females in regard, their opinions carried a great deal of weight. They pointed out that sexual desire and the wish to express the sexual emotions freely were not the sole provinces of loose women but belonged to any healthy female. These "nice girls," who were about to be married, admitted openly that they too longed for sensual pleasures with the same intensity as the men, and further admitted that they had not remained virtuous. Through these disclosures the men were able to realize the faultiness of their previous concept.

With this reassurance the males would begin to see that their overidealization of mother had left them with strong feelings of emotional loneliness. They then could appreciate the pattern of their purposeless behavior. The need of approbation and love had formed the basis of their multiple sexual outlets but had not brought any understanding of love to them. They further realized that their choice of so-called "loose women" for their sexual gratification never really gratified these feelings of loneliness but merely kept them on a meaningless treadmill.

Quite frequently, once the males had exposed their sexual torment, the females in the group were encouraged to talk about a problem that had a close proximity—their excessive drive to have children. In a rather short time it became evident that this excessive need, with its preoccupation, had produced unknowingly a lack of comprehension and sensitivity to their potential husbands. It was as if they were so determined to have children that their recognition of the realities were being overlooked. This was true not only on a mundane level,

[2] Kotkov, Benjamin, "Unresolved Sexual Fantasies in Group Psychotherapy," *Psychoanalytic Review*, 44(July 1957), 313–22.

but equally in not taking into cognizance what the advent of a baby would do to their marriage. In other words, many of them revealed that they possessed the drive to have a baby almost as if this was the justification for being married, when actually it had been an unconscious drive to strengthen their own self-imagery. This drive expressed itself despite the fact that there was an emotional concern about their prospective husbands. But it would soon become evident that their concern for the prospective husbands' feelings had been placed secondary to their own ego-supporting interest through the need to demonstrate to themselves that they could have babies.

However, due to the influence of the group, it was not too long before they became more aware of their previous insensitivity and lack of relatedness to others. When this manifested itself through the challenge to cope with the various members in the group, they became more understanding of their previous self-limiting aims. Thus, the values in being able to relate to others without overinvesting in oneself or another human being at the expense of the whole group structure enabled the woman participant to have a more balanced perspective about her need to have a baby.

After working through the problems of multiple sexual outlets for the males and the females' excessive drive for maternalism, the groups were then ready to contend with the most volatile issue pertaining to their lack of self-worthiness. It dealt with those feelings of isolation which were driving both sexes into premature matrimony as a device for tranquilizing this basic anxiety. This critical phase was ushered in by the discussions of sexual gratification and childbearing. For then these young people appreciated that they had, in a manner of speaking, overglamorized the idea of being married. They had hoped to overcome the pain of the feelings of isolation through marriage without truly comprehending that marriage could not possibly serve as such a remedy. It is only fair to say that ofttimes this mistaken idea that marriage provides internal emotional stature had come not only from their own reasoning but even from their contemporaries' demands upon them to conform and be acceptable. When this phase was understood, a more healthy attitude as to what marriage was really like developed. They no longer had to depend upon matrimony to give them substance for their individuality. A confidence in themselves and their matrimonial undertakings then became evident.

With these gains, the last component involved in the dilemma of the premarital anxieties could be understood with clarity. This had to do with the sociological factors of education, culture and material backgrounds. These young people could then see that their regard for the existing differences in these areas was not the pivotal issue in whether or not their prospective marriages would succeed. Instead, through their group experience they could realize that these differences, although at times important, were not really the basis for the misunderstandings that creep into marriage. Rather, the ultimate result was the appreciation that the normally complex human being in a marital relationship with another normally complex human being creates a bilateral demand to relate with alacrity to this complexity without blaming its mishaps upon socio-economic factors.

In keeping with our short-term objective of reaching an emotional level compatible with a constructive entrance into marriage, the usual length of treatment was six months. The groups met twice a week for 90 minutes. It was the policy, even though many mundane difficulties were encoun-

tered, to close the membership once a group had started. Only people with moderate neurotic personalities were accepted. Those with more severe problems were treated with other appropriate measures.

SUMMARY

Inasmuch as there is a constant lowering of the median age level for first marriages in America, there is an ever-increasing need to make a suitable psychological treatment available to those who must face the resulting problems. Intensive group psychotherapy serves perhaps as an ideal setting to cope with these conditions.

Thus, when young people nearing marriage were placed in mixed groups they appeared to be aided considerably through the realization that there was a commonality of their problems regardless of their cultural, educational and financial backgrounds. Most often these problems were outgrowths of a failure to comprehend their own lives beyond a childish morality. This immature and severely judgmental view of life had been employed as their defense against the instinctual drives. And upon realization that they were lacking emotional appreciation of their basic drives, they began to understand that their feelings of unworthiness and poor personal identification had been the basis of their numerous problems.

It was their group participation which showed them that actually they had been afraid to relate in close personal contact. This became apparent to them through the recognition of a reluctance to discuss their fears. In this recognition, the accompanying increased security had encouraged the open sharing of the especially endowed fantasy material. And with this successful growth, coming as it did within the multiple human structure of the group, there developed a more resourceful personality for each of the individuals. There was a marked decrease of intolerance as well.

Through these interrelationships there came an end to a vicious parasitic cycle—excessive possessiveness that leads into helpless domination by others. In practice, it had proved that with the use of individual sessions the understanding of this cycle had been limited. It was only after experiencing this depleting bondage in the controlled atmosphere of the therapeutic group that the ability to resist and outgrow this form of behavior was attained.

Another gratifying development coming from the group experience was the rectification of the distorted views that were held responsible for inadequate marriages. These views had placed the causes solely upon matters such as money, educational levels, kinds of friends, relatives and social position in life. The inherent basic values of communal cooperation found in the therapy group made them realize that though such matters had their place in marriage the ability to work out an understanding with another person was the critical value involved. It was then appreciated that the person's dedication to meet and relate to the normal complexities found in all people had far more to do with the success of a marriage than any of the other factors.

In this new light of understanding, which comprehended the primary importance of human relatedness, the definitive problems took on a broader and different perspective. For example, the anxiety over infertility and impotency as well as the guilty feelings concerning masturbation and sexual experiences before marriage were understood as natural outgrowths of their incomplete psychological development. They then understood that, due to this immaturity, they had had to utilize defenses to checkmate themselves against such anxiety. However, they

further understood that these defenses had taken their toll by isolating them from their own feelings and by fostering their feelings of loneliness. The feelings of loneliness had driven many of them to attempt marriage as a panacea. But in their ultimate acceptance of all the individuals in the group, in the realization that their problems were universal, these young adults had a return of the feelings of belonging.

And finally, with their self-imagery realistically reinforced, they found themselves able to enter marriage with the comfort and confidence they had desired.

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Patient government ...a case study

One of the most challenging tasks social psychiatry faces is that of providing the clinical practitioner with a workable theory of social behavior in the hospitalized schizophrenic patient. Such a theory should make sense of the many diverse forms of interaction found in schizophrenic groups. It is hoped that this case study in patient government will contribute to the development of theory. It brings together the impressions and observations culled from participating in the formation and operation of a patient government composed of long-term schizophrenic patients.

SOCIAL BEHAVIOR IN THE SCHIZOPHRENIC

The major types of disturbance in social functioning that have received considerable attention in the literature have been the following: a desire for social withdrawal; an inability to sustain appropriate affective relationships with others; an excessive dependence and passive compliant orientation adopted toward others; a severe deficiency in communicative role taking and empathic skills; and a deficiency in motivation to work.[1] Almost all of the subjects of this case study fit this generalized description. What kinds of rehabilitative functions can the technique of patient self-government perform for such chronic schizophrenic patients?

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[1] See *Behavior Pathology* by N. Cameron and A. Margaret. New York, Houghton, Mifflin Co., 1951, and also "Withdrawal as a Dimension in Schizophrenia," by G. King, *Journal of Clinical Psychology*, (October 1956).

FUNCTIONS OF PATIENT GOVERNMENT

Patient government is regarded as a social instrument designed to reverse or minimize the effects of the regimentation of "total institutionalization" [2] upon the patient. Total institutions are characterized by the fact that they handle the human needs of their inmates by the method of bureaucratic organization of large blocks of people. Most large mental hospitals fit this description. The needs of organizational efficiency require that for most of his waking day the chronic schizophrenic patient be treated as part of an undifferentiated group, and that he be kept under almost constant surveillance. His verbalizations and feelings tend to be discounted because of their presumably pathological basis. His activity program and social contacts are regulated for him and sheer behavioral compliance becomes synonymous with health and adjustment. The long-term effects of such an atmosphere are that the patient expects the hospital or significant others to do the thinking and feeling for him.

The technique of patient government attempts to provide a milieu in which the patient is motivated, with group support, to express his ideas about problems in his ward or building, or in the hospital at large. A patient government group has certain characteristic relationships with hospital authority figures. The latter treat the patients' opinions and requests sympathetically and objectively. Hospital functionaries have a readiness to learn about patients' needs, to trade perspectives and to welcome patients' solutions to practical problems. With the sanction of hospital policy, personnel feel free to implement solutions in small cooperative groups set up to carry out decisions.

This case study begins with the formal structure of patient government as it actually developed, followed by a discussion of relationships to the social structure of the hospital.

STRUCTURE OF PATIENT GOVERNMENT

The senior author stimulated the organization of the patient government and has participated as its adviser during the past year. The patients chose to name the organization the Welfare Council. The council consists of chronic schizophrenic patients on one of the buildings of the continued treatment service at the Franklin D. Roosevelt VA Hospital at Montrose, N. Y. It is organized with a chairman, three vice-chairmen, a secretary and several committees. Meetings are open and are held twice weekly. The weekly executive meetings are restricted.

Membership is voluntary and new applicants are readily admitted with a vote of approval from existing members. (No applicant has yet been refused.) Membership is confined to the patients of building 4, which has 150 patients; 50 are *bona fide* members of the Welfare Council. The median age of council members is 36 years, which is somewhat younger than non-council members. The median length of their current hospitalization here is approximately 3.5 years. Almost all of these patients had been hospitalized at some time previously. They were all classified as chronic schizophrenics.

[2] "Total institutionalization" is a term adopted by Goffman to denote those institutions—such as mental hospitals, prisons and army barracks—which control and regulate the major life activity of inmates and segregate them from outside involvement and intercourse. See "On the Characteristics of Total Institutions," by E. Goffman, *Proceedings of the Symposium on Preventive and Social Psychiatry*, Washington, Walter Reed Army Institute of Research, April 15–17, 1957.

ROLE OF THE ADVISER

The adviser has been most active in training the president and the three vice-presidents in leadership techniques. In small group discussion, such topics as the following have been covered: conducting a meeting, achieving a proper balance between order and permissiveness, how to encourage wider participation, setting up committees, how to conduct an interview with a hospital authority, how to cope with hostile patients, etc.

Patients are encouraged to attend council meetings and to bring grievances and suggestions for the improvement of ward life to the group's attention. The adviser or his alternate is present at each meeting. The slightest indication of the withdrawal of support is immediately detected by the patients and they quickly relapse into apathy. Old habits of conformity and inhibition of constructive thinking constantly intrude upon the processes of patient government. These do not wither away with the introduction of free discussion. It is necessary to continually remind the patients that the discussion and criticism of current practices and routines of the hospital are not only allowed but that patient government was fostered by the hospital management for this very purpose. In the early months of council the hostile patients were of considerable help in demonstrating that the hospital could react constructively to criticism.

The adviser meets with individual patients to assist them in developing new projects and tasks for the council and its committees. This kind of grass roots work with the chronic schizophrenic is considered essential to the success of patient government; each individual patient leader needs support to feel certain that his ideas are not subversive of hospital authority, that his right to express his beliefs and feelings are inviolable. Here and there it might be desirable to avoid the council's meeting with certain individuals who are out of sympathy with the idea of patient government until it is securely launched. Meetings between hospital authorities and council officers are arranged when requested by the adviser.

Chiefs of service and other functionaries are invited as guest speakers. In the ensuing discussion the patients get a clearer picture of the structure of the hospital, and as a result many regulations have come to have meaning and to seem less arbitrary.

In spite of the adviser's high level of activity in stimulating interest in new tasks for the council he tries to maintain a neutral position both at the general meetings and in the council's negotiations with hospital authorities. The adviser ought not place himself in the position of having to take responsibility for the recommendations of the council, nor of championing one group of patients against another. Only when the basic processes of the patient government itself are at stake does he clearly demonstrate where he stands. When the meeting threatens to become too disorderly he backs up the chairman; when the chairman rules that a given subject may not be discussed in the council he reminds the members they may discuss anything the group decides to; when a hospital worker attempts to misuse the Welfare Council he clarifies their relationship to hospital authority. The decisions of the council are largely recommendations to various hospital personnel.

INTRA-GROUP PROCESS

In general, the members of the council consist of the more improved patients in the building. They see themselves as a select group and feel that their prestige would be diluted if they were to widen their

membership and thereby operate in close association with deteriorated patients. During the first six months of the life of the council the majority felt that the membership should be limited though the number admitted was gradually raised. There was a fear that the purposes of the council would be inundated by a large number of sick patients. Later experience showed these fears to be largely unfounded since few of the regressed patients are seen at the council meetings.

It is probable that the clinical practitioner who seeks to widen and intensify participation in patient government would be likely to face this problem. Possibly the improved patient senses the value orientation which views healthier patients interacting with deteriorated patients as negative or inappropriate. Patient government itself can modify these values.

Patients were unaccustomed to the required role of active participation. They came to meetings with a passive and imbibing orientation. It was easier to mobilize their interest than to galvanize them into action. This was not simply a function of the schizophrenic withdrawal. Rather there was a multiply reinforced assumption that taking action was contrary to their role as improved patients. *Action* for them seemed to mean *wrong action*. They automatically relied upon guidance from the adviser for the problem-solving modes to select. Their helplessness was evident when a proposal was made to change some procedure in the building. The patients would subject the proposal to the test of whether the hospital authorities would approve it. The screening process was partly reality testing (Would it be seen as practicable by the hospital?), partly ego testing (Does a healthy person make this kind of request?). Only after a proposal passes these tests are its merits considered by other criteria.

The persistence of this group dynamic is evidenced in the patients' repeatedly turning to the adviser for his opinion about a given proposal in spite of the fact that he has both implicitly and explicitly structured his role as an impartial agent. This imputing to the adviser of a role that he disavows both verbally and in practice flows from two quite different needs. The primary one is the need to have the adviser as an active ally and defender; the second is the paranoid need to see all processes of the hospital administration as selfishly motivated. Patients with paranoid attitudes still suspected that behind the adviser's neutrality lurked a commitment to the administration which had to be exposed.

The chairmanship of the meeting rotates among the president and three vice-presidents. This device enables more patients to have leadership experience and provides for an easy transition of leadership when a president is absent or leaves the hospital.

At this time, it seems difficult to point out any clear relationship between type of behavior pathology and leadership ability. However, it became clear that the patients required a forceful and active leader. Two of the council's most stimulating and effective leaders were classically hostile in character structure. This observation has tempted the authors to consider the hypothesis that hostility may be correlated with certain personality factors necessary for leadership in the context of long-term hospitalization. Those presidents who succeeded in motivating the patients into programs of activity did so by prodding individual patients and by seeking out contact with hospital authorities, thereby achieving concrete changes.

INTER-GROUP PROCESS

The majority of patients use the council as a means of achieving material improve-

ments in their way of life in the building. Some of the major changes that the council was instrumental in achieving were the setting up of a special recreation room, the changing of certain cafeteria arrangements, the establishment of a buddie system to aid regressed patients in eating and grooming, and the appointment of "contact men" to help the nursing assistants in certain chores.

Topics which elicit the highest interest and widest participation are grievances, requests for additional privileges and freedoms, and departmental functions and regulations as explained at council meetings by the hospital administrators.

Patients suggest a large number of ideas for innovations in the building. Most of these are never formally passed upon by the council, either because they are not effectively presented by their sponsor or because they seem lacking in merit. However, the main problem lies in the subtle social paralysis which develops when it comes to the implementation and reality testing necessary to crystallize such ideas into practice.

The council's officers have influenced various hospital personnel with whom they have come in contact. Particularly operating personnel, who normally have little direct contact with patients, have had to revise their image of the mental patient and reconcile it with the reasonable and cooperative attitudes the council officers have shown in their conferences with supervisory personnel. When the patient's requests cannot be granted the committeemen or officers have accurately and sympathetically reflected the administrative point of view in their reports to the patient group. Hence, there has been a reduction in hostility between patients and personnel, an emergence of an *esprit de corps* in the building, and an increase in patient-to-patient and patient-to-personnel communication. There is a widespread understanding of the reason for many hospital regulations and policies which were formerly regarded as demeaning to the patient.

The active members of the council have been somewhat fearful and guilty that their desire for innovations might be considered subversive or pathological. There was the added fear of being ineffectual and exposing oneself to ridicule. With continued experiences of success in group action and the validation of individual suggestions, such fearful attitudes have declined. These emotional doubts were not without some basis in reality. There were occasions when a council request was interpreted as motivated by pathology or as indicative of poor judgment. Such interpretations outside the framework of individual or group psychotherapy is often a defensive maneuver, and can be a serious obstacle to the process of patient government.

It is considered crucial that a request of the patient government be negotiated on its individual merits, and in terms of hospital policy. An active patient goverment may threaten existent modes of functioning and well-oiled routines. The success of patient government depends heavily on the willingness of the hospital personnel to expose themselves to critical scrutiny and professional self-clarification. The absence of this kind of zeal in the milieu can be as great an obstacle to the success of patient government as the effects of mental illness and prolonged hospitalization. When patient government operates outside the mainstream of the hospital's functioning, it becomes a localized technique and as barren as a "gimmick" in its therapeutic effectiveness. Patient government may be no more than a window dressing designed to make the hospital look modern.

EFFECTS OF PATIENT GOVERNMENT ON INDIVIDUAL PATIENTS

Patient government stakes its efficacy upon developing and expanding the residuals of affect and constructive interests within the patient. Starting with the simple concrete needs of long-term thoroughly institutionalized patients, patient government attempts to wedge into the finality and drone of the hospital's daily routines. Repeatedly the patients have learned through the granting of their requests that things need not always be as they *are*. The patients find that they themselves can affect their physical and social environment in ways which are beneficial to them.

Patient government gives added responsibility to patients, provides an arena in which the handling of responsibility can be evaluated for prognostic purposes, and permits the patients to behave in a more community-like setting. It gives substance to the notion of a therapeutic community. When operating at its best, patient government impels the patient to examine the obstacles to his better functioning as a human being. The attitude of love and acceptance, the freedom to state one's feeling and thoughts without fear of ridicule, and the invitation to active participation in recreating the life of the ward are all necessary ingredients for the process of resocialization as well as patient government.

Let us give a concrete example of this parallel: In the midst of a heated discussion, one of the sicker patients once made a long repetitive harangue; the others listened with embarrassment, irritation or patience but without interruption. When the chairman, expressing the sentiments of the council, gently chided him to express himself more directly and simply, the patient responded with appropriate affect by saying, "Thank you all for the charity of listening."

In any large "total institution," there is likely to develop such a rigidity in organizational structure that it becomes dysfunctional to the attainment of its avowed aims. In the case of the mental hospital, discrete special-interest groups operating independently to achieve narrow "therapeutic" goals may produce a resultant pattern which militates against patient rehabilitation. Constant evaluation of the organization's operating practices from several differing perspectives of experience is an excellent safeguard against the "freezing" of organizational practices that have become divorced from rehabilitation goals. This is one of the basic reasons why it is in the interests of hospital administration to nourish and encourage the formation and sphere of influence of patient government.

The experience with patient government during the past year has left the authors with the conviction that it is a significant technique for remotivating chronic schizophrenic patients. This paper as well as others in the literature suggest numerous hypotheses for controlled investigation into this aspect of social psychiatry. Through research the impressions and hunches surrounding this treatment technique may be wrought into a valid adjunct to the scientific management of patients.

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Aggressive behavior of staff members in a neuropsychiatric setting

The psychological literature abounds with detailed discussions of the psychodynamic significance that hostility may have for emotionally disturbed individuals and with the multitude of different ways in which patients may express this hostility in overt behavior. Relatively little attention has been paid, however, to the manner in which certain hostile feelings of professional staff members themselves may affect the subtle interplay between one staff member and another and between staff members and patients. Since the nature of these interpersonal relationships very probably helps determine in a significant way the over-all effectiveness of any therapeutic program, it seems essential to subject these interactions to the same careful examination that is customarily applied to the other elements of the therapeutic process. Moreover, for a fuller comprehension of the whole treatment situation, an effort should be made to delineate some of the personality and situational variables which could, at least at times, account for changes in the intensity or manner of expression of hostility in the professional staff.

The purpose of this paper, therefore, is to report on some of the relevant personal experiences and observations of the authors which they encountered while working for several years in a large neuropsychiatric service of a highly respected military hospital.

It is recognized that in failing to utilize

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experimental techniques and in relying exclusively on subjective impressions, this study is beset by the usual limitations attending such an analysis. Despite the possibility of distortions in the interpretations of observed events which could result from personal biases of the observers, it is felt that a common sharing of even these limited and subjectively evaluated experiences might be of considerable help to other workers, specifically those of the three disciplines—psychiatry, psychology and social work—who are functioning in a similar type of setting. Although some of the generalizations might require modifications depending upon the specific hospital situation in which the professional worker finds himself, some of the insights gained might ultimately contribute to a more effective use of the skills of the professional worker and thereby lead to improved patient care.

Before embarking on a discussion of the specific types of hostile behavior patterns which have been noted in members of the staff, it might be appropriate to describe very briefly the hospital setting in which these observations were made. This particular neuropsychiatric service was the largest of any within the United States Air Force. It formed an integral part of one of the most respected and one of the largest Air Force hospitals in this country. Its function was to provide appropriate diagnosis and treatment to military personnel and their dependents who were referred by other installations located in various parts of the United States and overseas. There were facilities for closed and open ward patients, for all the psychosomatic therapies, including electric and insulin shock, and for outpatient clinic visits. Although the precise composition of the staff varied with time—not only with respect to who was assigned to any one position, but also with respect to the number of people assigned—there were generally a minimum of 6 psychiatrists, 2 neurologists, 3 psychologists and 2 psychiatric social workers on the staff. In addition, the staff was supplemented by approximately 20 nurses, 40 psychiatric corpsmen, 3 enlisted technicians and certain ancillary personnel such as Red Cross workers, occupational therapists and physical therapists who were also available but not assigned directly to the neuropsychiatric service.

The assumption that all behavior is determined or multiply determined will be basic to the discussion of our observations; furthermore, we believe it is reasonable to assume that behavior at any particular time is dependent upon the interaction of conscious and unconscious, internal and external factors affecting the individual. Presumably, then, there is a cause-and-effect relationship between overt behavior and the underlying conflicts, needs, drives, attitudes and value systems which represent the individual's personality. Verbal expressions, including those having a hostile overtone, are considered to be equally subject to these explanatory principles and may originate from a variety of personal conflicts, needs, drives, attitudes and value systems.

When plans for this project were first formulated and subsequently developed it seemed that it would be possible to identify certain areas of conflict which could be directly related to various manifestations of aggressive behavior. The opportunity of identifying areas of special stress was thought to be excellent since all of the usual forces which are often thought to engender hostility were operating in our setting. For example, there were regular and non-regular, new and old officers, supervisors and subordinates, and different professional and subprofessional workers holding a variety of diverging views on the causes and treatment methods of mental disorders, ranging from

the most organic to the most functional, from the most dogmatically orthodox to the most radically unconventional.

However, as observations of staff behavior were made and as the information was recorded it soon became evident that the verbal expressions of hostility failed to fit neatly into any specific conflict categories. The causative factors which are often considered to be most related to the expression of hostility failed to account for a considerable part of the observed behavior. Consequently, at least for purposes of this paper, it seemed more advisable to describe hostile staff behavior as manifested in three very broad types of interpersonal relationships. The areas of observation which were finally selected were: inter- and intra-professional relationships, supervisory-subordinate relationships, and staff-patient relationships.

INTER- AND INTRA-PROFESSIONAL RELATIONSHIPS

Inasmuch as personal contacts among members of the same or different professions are much more accessible to observation than those between staff and patients or between supervisors and subordinates, we have available for reporting a greater number of interactions illustrating the expressions of hostility in the first area than in the others. Let us cite some specific examples of hostile behavior relevant to this area of interaction:

At a weekly professional staff meeting of the neuropsychiatric service an announcement was made concerning the required rating which would entitle nurses to membership in the officers' club. This rating, reflecting level of responsibility, was then translated into the salary equivalent and it was noted that most nurses fell within a relatively low range. One of the physicians thereupon inquired facetiously, "That is all nurses are worth, isn't it?"

The following verbal exchange occurred at lunch between a nurse and a physician. The male nurse expressed his need to return to the ward to attend to some patients whereupon the physician replied, "Why, I have yet to see a nurse do any work since I came here." The nurse then retaliated with anger, "If you physicians ever came out of your cubbyholes and quit hiding, you might know what was being done on the ward."

Another instance of aggressive behavior arose out of the fact that on several of the wards regular meetings were conducted of the ward personnel for the purpose of discussing common problems or new patients who had been admitted. At one of these meetings the ward physician presented a treatment plan which affected ward procedures and involved all of the personnel. This plan met with considerable resistance on the part of the members. For example, one nurse described this suggestion as "a lot of junk." The wardmaster added, "If you had to spend your time on the ward the way I do, you would do it differently." By virtue of the ward physician's decision-making function, the plan was eventually adopted despite the opposition. The doctor's closing remark to the rest of the staff made the point without equivocation that he considered the previous method completely antiquated and that it would have been more appropriate in the 19th century than at the present time.

It was also customary in our service to hold weekly staff meetings at which time a variety of information was disseminated and an opportunity was afforded for problems of importance to be presented by any member for general discussion and possible resolution. At one of these meetings the chief psychologist mentioned that referrals for psychological testing were frequently forwarded to the wrong section, and he out-

lined the acceptable referral procedure. One of the physicians thereupon immediately remarked, "Why make referrals at all since patients are usually discharged long before we get the report?"

In reference to psychologists and their tests, the following represent some typical hostile comments directed at them: "The thing I dislike about psychologists is the continual hedging which they do"; "They never tell us anything we don't know." In addition, on two separate occasions different physicians likened psychological reports to routine laboratory reports. It is noteworthy in this connection that during informal conversation and at the staff meetings the psychologists often reminded the physicians that psychological test findings could be of greater value to them if they were done following consultation between psychologists and psychiatrists on the specific purpose of the testing and on the kinds of information that were desired. Also they suggested that certain information could not possibly be arrived at by means of tests.

In the setting we are describing it had been one of the functions of the social work section to provide social histories on newly admitted patients. The staff physicians, psychologists and ward nurses on several occasions were noted to express themselves in the following manner: "It seems to me that the social histories are nothing but a fact sheet"; "All the social histories do is duplicate information already available." In some instances physicians have asked the social workers, "Why do you waste your time taking histories since they are never used?"

It had been the practice of social workers to conduct regular group therapy sessions for the patients on some of the wards. This situation often resulted in the social worker's being made the target for many expressions of hostility. One of the physicians, for example, strolled through one of the wards shortly after the group meeting disbanded and inquired of the social worker why he conducted those group "seances" every morning.

Illustrative of hostile feelings directed toward the medical staff was the fact that many of the physicians were referred to as "pseudo-psychiatrists" or "90-day-wonder psychiatrists" by the social workers, psychologists and nurses. This comment was based on their short training period in psychiatry. It should be noted that some of the psychiatrists had received only 90 or 120 days of on-the-job training by the Air Force in the field of psychiatry and had been completely inexperienced in the psychiatric field prior to their entry into the service.

Furthermore, the psychiatrist's role was often defined by other staff members as that of an administrator who made dispositional decisions rather than that of a person who understood and treated emotionally disturbed patients. On some occasions the psychologists, psychiatrists and social workers were accused by the nurses of not being able to communicate satisfactorily with them and of not being able to comprehend the demands of the nursing service in establishing a smoothly functioning ward.

Many of the manifestations of hostile feelings as expressed verbally by staff members failed to follow the general pattern so far described under the discussion of inter- and intra-professional relationships. Much of the aggressive behavior noted seemed to bear no discernible relationship to membership in a particular professional group. Instead, the expressions of hostility often appeared to represent more basic personality reactions rather than specific role-oriented behavior. The following illustrations taken from both scheduled and fortuitously formed social contacts of the neuropsychiatric staff reflect hostile reactions apparently

unrelated to the particular group with which the professional worker identified.

For example, a staff member who was found sitting idly in his office was greeted by more than one of his fellow workers with the query, "When do you expect to start working?" and "Have you stopped seeing patients?" Similarly, a staff member who was seen away from his customary place of work was asked, "Where are you goofing off today?" and "Have you found a new hiding place?" Remarks like the preceding ones were a common occurrence and no staff member was immune from them.

At a recent meeting, one of the professional workers rationalized his declining additional responsibility by claiming to have insufficient time. This elicited responses such as, "If you worked from 7:30 A.M. to 4:30 P.M. you would have the time" and "What do you mean, no time? I haven't seen you do anything at all recently."

Several ward physicians who were assigned to the open wards occasionally held staff meetings at which problems occurring on their wards could be discussed. The granting of daily and weekend passes to patients was causing some discontent on one of the wards. This problem was mentioned by the ward physician. The response from another physician who came from the adjoining ward was, "I have never had this problem and if you spent more time on your ward maybe this would not be a problem for you either."

One of the staff psychiatrists who felt it was therapeutically important that patients be permitted to engage directly in decision-making on their respective wards and also be participants in some of the staff conferences presented this concept to some members of the staff. A veritable barrage of hostility greeted him in response to this suggestion. One comment that was made immediately was, "It has been done this way (without having patients in attendance at conferences) a hundred years and you think it can be changed?" Other responses were "It will never work, and in addition I cannot see how any benefit would be derived from the change." One of the men declared, "It sounds fine in theory but let's be practical about this."

In any large institution powerful forces appear to be operating that discourage marked divergencies from the norm in working schedules and methods of performing the work. Those slight differences that existed in the neuropsychiatric setting described here often became the object of hostile remarks. For example, a newly arrived staff member demonstrated what was considered to be an unusual amount of zeal for working relatively long hours and also displayed much enthusiasm for initiating new time-consuming procedures. In a few days another physician expressed the feeling that he wished the new man would turn off his "super-charger." In addition, almost every staff member who found himself in a position of appearing occupied most of the time would be accused of "bucking for promotion" or would be informed that there is no relationship between amount of work performed and compensation received. The above-cited staff member was similarly informed by a co-worker that he would soon learn about the military. His naïveté allegedly stemming from his recent arrival in the military service was commented upon by others who implied that he would do things differently as he became more accustomed to the service routine.

In direct contrast to the situation described above stands another episode which occurred when a staff member arrived and soon demonstrated erratic work habits. He seemed indifferent to the usual routine of conferences, staff meetings and other requirements of a semi-mandatory nature.

This carefree, unconcerned appearance did not go unnoticed and in a short time certain comments were made. One co-worker inquired, "When do you expect to start working?" Another person sarcastically remarked that he certainly adjusted quickly to the military. He was also asked if he intended to make a career out of the service or expected to "go regular." It was also observed that at one of the staff meetings when this member's absence became conspicuous one of the physicians pointedly remarked about his absence to the chief of the service.

Some of the staff physicians were in analysis while working on the neuropsychiatric service. On more than one occasion when one of these physicians expressed his opinion in a staff conference or in an informal discussion, the co-worker who disapproved of a particular point of view asked whether he had any difficulty with his analyst that day. Moreover, at times it would be suggested by one of the staff members that the individual in analysis had better "work that through" with his analyst.

To conclude the section pertaining to inter- and intra-professional expressions of hostility, it might be added that one particular expression was used quite frequently and indiscriminately by many of the staff members—they referred to a co-worker as being "sick." Ascribing to another professional worker poor mental health whenever one disagreed with his point of view or disapproved of his behavior seemed to epitomize the intense hostility felt on occasion. The word *sick* seemed to be the one descriptive term which carried with it the greatest justification for the rejection of that individual.

SUPERVISORY-SUBORDINATE RELATIONSHIPS

Indigenous to any complex organization or institution such as a military hospital is a hierarchy of responsibility and authority necessitated by the desire and need of all concerned for a smoothly functioning operation. An organizational or administrative structure like the one described in this paper seems to facilitate the occurrence of interpersonal conflicts between those individuals who have a greater and those having a lesser amount of authority and responsibility. In the neuropsychiatric service we are describing, ample opportunity was afforded for observation of hostile interplay between supervisors and subordinates.

For example, a psychiatrist who held a supervisory position and who felt his authority was being encroached upon by a secretary on one occasion during staff conference turned upon this secretary and asked, "How many hats are you wearing anyway?" This same supervising psychiatrist, who initiated some different procedures after his arrival, became the recipient of a veritable barrage of hostility from some of the subordinate staff psychiatrists, who referred to him as "The Great White Father." This was only one of many derogatory names attached to this supervisor by his subordinates. Apparently the labeling or nicknaming of individuals presented a convenient and common device for expressing hostile feelings toward supervisors and subordinates. To cite another example, a rather aggressive and manipulating airman who occupied a position within the clinic structure where he exerted a greater degree of control over scheduling appointments than is ordinarily the case was often the object of considerable hostility. Even though he was an enlisted man, he would frequently be addressed as "Colonel" by the physicians and other professional staff.

It was a well-known fact that many of the professional people on the staff had a professional title by which they preferred to be addressed rather than by their military

rank. It seemed as though one of the favorite ways for a subordinate to express hostility toward a supervisor or higher ranking member of the staff was to refer to him or address him by his rank rather than his professional title. For example, one of the staff members always referred to the chief of the service by his military rank rather than by the title *Doctor* whenever he objected to one of his proposals.

Perhaps one of the most interesting examples of expressed hostility took place at a weekly conference devoted to discussing therapeutic techniques. This meeting was conducted by one of the supervising psychiatrists. The psychiatrist in charge preferred a particular chair located in a particular part of his office. There were many instances in which some of the subordinate staff physicians would contrive to rearrange the chairs prior to the supervisor's arrival, seat themselves in the preferred chair, or make certain that all of the chairs were occupied, thereby attempting to precipitate an embarrassing situation for their "supervisor."

There are several further illustrations reflecting a considerable amount of hostility in the relationships between supervisors and subordinates. For example, an enlisted man who reported to the neuropsychiatric clinic was assigned by the clinic supervisor to fairly menial duties which were not commensurate with his rank and experience. This was a departure from the previous policy of assigning the less desirable duties to the lower ranking and less experienced technicians. To illustrate again the role which hostility may play in the assignment of duties, a staff physician was assigned to one of the psychiatric wards and given certain prescribed duties; he inherited the same title and responsibilities as his predecessor but subsequently found that the decision-making power of the assignment had been assumed by his supervisor.

To offer another example of hostility, let us again use the staff meeting as the setting. Some of the staff members at the weekly staff conferences presented problems or posed purely academic questions which could not be solved immediately or over which their supervisors could have no control. In these instances the purpose was often to embarrass the supervisors in front of other staff members.

Although on an over-all basis approximately as many hostile expressions were observed in supervisor-subordinate relationships as in other interactions, the former tended to be more covert, indirect and guarded than the latter. Since the critical remarks of supervisors and subordinates were restricted, in the main, to the privacy of their respective in-groups, it was more difficult to document these expressions than the hostile expressions occurring during other interactions.

STAFF-PATIENT RELATIONSHIPS

The interaction of patient and therapist has been the subject of much scrutiny and study, as have some of the multiple environmental factors which promote or interfere with therapeutic change. The literature abounds with discussions concerning the effect that the attitudes and feelings of the staff have on patient care. We are attempting in this section of the paper to illustrate only staff expressions of hostility toward patients. Because of the confidential nature of individual interviews with patients and the prevailing philosophy that people who are caring for mental patients should be accepting, objective and emotionally controlled in their relationships with patients, the feelings of hostility expressed toward patients are apt to be less overt than those toward co-workers.

It is expected that a certain proportion of patients will be referred to any medical center who actually do not require hospitalization. In spite of this realistic problem, admitting physicians often seemed to utilize this fact as a means for ventilating their hostile feelings towards patients whether they required hospitalization or not. For example, quite frequently the staff physician who was responsible for screening all new patients would be heard to remark indiscriminately, "Why did they send him here?" This type of reaction was noted not only on the admission service but also in the outpatient section as well as on the open ward sections to which patients were subsequently transferred. Frequently the ward physician would react to his frustration resulting from his inability to cope with a therapeutic problem by being overly eager to rid himself of the responsibility of caring for a patient. Thus, for example, a physician might remark gleefully, "I don't want him, you can have him, he's too sick for me!" upon transferring a patient to another ward. Some physicians were equally eager to discharge patients from the hospital as expeditiously as possible for the same reason.

Some of the professional and subprofessional staff adhered to the philosophy that patients should not be coddled but should be disciplined rigidly in accordance with military practices. It was not uncommon to hear a ward nurse or wardmaster ask a patient, "Do you think this is a hotel?" or comment, "This patient acts as if he were visiting a country club." Occasionally patients were asked by their physicians, ward nurses or corpsmen whether they were enjoying their "vacation." Even at one of the ward staff meetings it was noted that in discussing the ward and the patients one staff member repeatedly commented that the patients "sure have it 'made' here, don't they?"

One of the wardmasters whose duty it was to select patients for a variety of chores around the hospital sometimes described the patients as a "bunch of crybabies." He also would attempt to obtain from the professional staff support for his contention that they behaved like immature children.

An outstanding illustration of staff hostility toward patients was the frequent tendency of the professional person to depreciate the potentialities for mental health of his patients. As a consequence, not only were patients often described as being more severely disturbed than they actually were, but also they were often considered to be inherently incapable of making an adequate adjustment. The frequent description of patients as representing "piss poor protoplasm" seems to reflect an attempt at justification by the professional person for his failure to make significant therapeutic progress with his patients.

SUMMARY AND CONCLUSIONS

The above-cited illustrations of aggressive behavior by staff members represent only a relatively small proportion of all such activity that was observed. Our intention was not to present a fully documented account of all aggressive behavior during a specified period of time but to offer a sufficient number of selected examples to enable the reader to get the flavor of this type of interpersonal interaction.

The most significant conclusion to be drawn from our observations is that hostility as a factor in staff relationships is an identifiable variable and capable of being subjected to investigation. Furthermore, it seems that hostile expressions of staff members are much more prevalent than is generally recognized. We have demonstrated in this study that these feelings may be revealed by means of a variety of verbal expressions, many of which are couched in

pseudo-facetious terms, and that they occur in a number of different situational settings, most of which would betray nothing of a hostile connotation to the casual observer.

The precise role that this type of agressive behavior plays in terms of therapeutic results remains obscure. However, it would seem that a lack of awareness by the professional worker of when and how he is resorting to hostile behavior in his interpersonal relationships is especially detrimental to the welfare of the mental patients with whom he comes into contact. It is not our contention that all hostile staff expressions necessarily result in destructive consequences for a therapeutic program. We do believe, however, that if the irrational basis for hostile feelings and associated behavior patterns remain repressed, hostility will tend to be poorly controlled, and an obstacle toward the basic acceptance of other staff members and/or of patients may be the result. The validity of this hypothesis awaits further study.

A number of other hypotheses suggested themselves as we focused our attention on the manner in which professional personnel express their hostile feelings. One of these is that hostility will tend to be expressed more readily in those situations in which the professional worker feels less secure. Insecurity may stem from internal conflicts and problems related to early childhood experiences or from stressful situations even in the absence of any basic conflict. If the insecurity is based on neurotic, unrealistic motives, the resulting hostility is likely to be less amenable to change than is insecurity based on situationally determined, more realistic factors. For example, it would seem far simpler to alter the intensity or direction of hostility of a psychiatrist who feels frustrated because of his inadequate training for a particular assignment than to change the hostile patterns of a basically maladjusted individual.

Another hypothesis which might be advanced is that hostility will tend to be more readily expressed in those situations in which the social subgroup with which the individual identifies himself reinforces and encourages this type of behavior. This hypothesis would explain the frequency of interprofessional conflicts, and, because there are multiple identifications at one and the same time and on different occasions, intra-professional conflicts as well.

A third hypothesis derived from our observations states that hostility will tend to be expressed more directly in those situations in which the apparent object of the hostility is perceived as being relatively weak, ineffective in retaliating or isolated from social support by others. The obverse hypothesis states that hostility will be expressed more indirectly in those situations in which the apparent object of the hostility is perceived as being relatively strong, effective in retaliating or allied with others whose support he can rely upon. Thus, for example, hostility will tend to be more frequently and openly directed at a psychiatric consultant whose theoretical orientation differs from that of the chief of the service than at a consultant whose theories are frankly supported by the chief of the service.

An important hypothesis having significant implications for the introduction of ameliorative measures is that hostility will tend to be expressed more readily in those situations in which the individual lacks awareness of his motives. In case a person freely relies upon the mechanisms of repression, displacement and rationalization, he would also be disinclined to accept the desirability of change in his hostile behavior.

Obviously all of these hypotheses require further study and evaluation before they can be accepted or rejected. The very fact that so many promising areas of research have developed from this project attests that this is a fruitful approach to the problem of staff hostility. It is hoped that other research workers who share an interest in these long-neglected problems will find our observations useful and, hopefully, will follow through with some of the hypotheses which have been tentatively advanced.

In conclusion, we would like to emphasize that contrary to the impression one might get from reading only these selected illustrations of hostile staff interactions, the over-all atmosphere prevailing in this hospital was generally a positive one, conducive to emotionally rewarding experiences for both the staff and the patients.

WILLIAM L. PELTZ, M.D.
WILLIAM R. CRAWFORD, M.D.

Assistants in the private practice of psychiatry

This report describes several types of assistantships in the private practice of psychiatry, a subject on which no previous reports have appeared in the literature. Moreover, it includes reactions to such arrangements obtained by means of questionnaires from 100 psychiatrists throughout the country.

The authors believe that the paper contains information which will be of interest to busy psychiatrists who would like to extend the scope and effectiveness of their clinical work. They also believe that it will be of interest to young men who are embarking upon their psychiatric careers and want further experience after their residencies or who need the financial security of a part-time or full-time job. It is believed that a senior man can extend his own efforts further in the direction of mental hygiene by having assistants in his practice and that he can offer his assistants knowledge and experience along these lines which they had not received during their residency training program.

During recent years, at the Institute of the Pennsylvania Hospital in Philadelphia several members of the staff, including the late Dr. Edward Strecker and Drs. Kenneth Appel, Joseph Hughes, Manuel Pearson and the senior author, have had one or more assistants working for them.

The arrangements of these men vary somewhat. In some situations it may be customary for new patients to be worked up by the assistant before they are seen by the senior man, whereas in other situations the senior man sees the patient first. Some

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arrangements are on a full-time basis which do not permit the junior man to see private patients of his own; others are on a part-time basis with a definite number of hours of the assistant's time being designated for the senior man; and still others are flexible in this respect in that the assistant is on his own except when he is seeing patients whom the senior man asks him to treat for him. Some senior men meet almost daily with their assistants to discuss the patients; others meet once a week or less frequently. In some plans a certain percentage is paid to the junior man, depending upon his experience or ability; in others a flat salary is paid; and in still others there is a basic salary with a bonus which is decided upon by the senior man.

The senior author, a psychoanalyst by training, is engaged in half-time practice of psychiatry and half-time teaching at a medical school. His efforts in the direction of mental hygiene in preventive psychiatry lie in connection with his teaching psychiatry to future medical practitioners and with his serving as consultant to the Marriage Council of Philadelphia and the Lawrenceville and Hill Schools, these being fairly large boys' boarding schools not far from Philadelphia. The primary reason for his taking on a half-time assistant five years ago was that when his schedule was crowded he was frequently called upon to see students at these schools. He was generally able to carry out consultations but often could not take the students on in therapy because his schedule was filled. The schools and he both felt that as consultant he could be of greater help to the school if he had an assistant treat some of the students. He could thereby remain in closer contact with the therapy situation than if he referred the students to colleagues. Moreover, he could see the students' parents or talk things over with the school authorities without his doing so interfering with therapy to the same extent as it might if he himself were treating the students.

In this particular arrangement the assistants usually work for the senior man for two or three years. They have ordinarily begun on a half-time basis (20 hours a week), the rest of their time being devoted to their own practices. While seeing the senior man's patients in his offices, they are building up their own practices elsewhere. During the second year they usually work about 12 instead of 20 hours a week for the senior man, and the third year about 4 hours. During the third year the senior man has taken on a second part-time assistant.

In addition to being available at any time for emergency conferences, the senior man spends an hour every week going over cases with the assistant during the first year they work together. During the second and third years, such reviews are held less frequently.

Letters to referring physicians about patients being seen by the assistant are usually drafted by the assistant, gone over by the senior man and sent out over the senior man's signature.

Billing of patients is done by the senior man, listing the dates of visits made by the senior man separately from those made by the assistant. A statement appears on the bill to the effect that the bills are payable to the senior man.

During the first year the assistant receives 60% of the gross income from patients seen for the senior man during the 20 hours per week assigned for the senior man's use. (The amount of $4,000 is guaranteed.) During the second year the assistant receives 70% of the fees instead of 60% and during the third year he receives 75% of the fees from patients whom he has seen for the senior man.

When the assistantship ends, in the authors' arrangement (in contrast to some arrangements in which the senior man retains all of the patients for himself), the assistant and senior review together all the assistant's cases and decide what the disposition of the latter's patients should be in terms of the needs of each patient. The matter is then discussed with the patients. Some patients terminate therapy, others transfer to the senior man or to another assistant, and still others continue with the original assistant in the latter's practice.

A matter of simple arithmetic will reveal that with fees averaging around $15 an hour and with an assistant working 20 hours a week for 48 weeks, the assistant would receive $8,640 and the senior man $5,760. Actually, because of empty hours, cancellations, etc., the gross amounts are less than these figures. Extra secretarial time, office supplies and time devoted to supervision during which the senior man would otherwise be seeing patients means that the senior man has netted about $3,000 during an assistant's first year and usually about the same during the second year.

To find out what other psychiatrists think about arrangements involving assistants in the private practice of psychiatry, a questionnaire was prepared and distributed to over a hundred colleagues in various parts of the country. The first 100 replies were analyzed, all but 5 of them from psychiatrists who have been in private practice. A total of 68 have had or are receiving psychoanalytic training. Of the 100, 49 have had experience in practice either as assistants or with assistants and 18 of the 49 have had assistants working for them. The remaining 51 have neither worked as assistants nor had assistants.

Several observations based on a statistical analysis of the responses, seem worth reporting.

Although there were felt to be both advantages and disadvantages to patients, to senior men and to assistants there was more expression of favorable than unfavorable reaction toward assistantships in this group of 100 psychiatrists. Respondents who had experience as or with assistants had a somewhat higher opinion about the advantages of assistantships than did respondents without such experience, and so did respondents without psychoanalytic training as compared with respondents with analytic training.

Whether or not they had ever worked as assistants or had had assistants, respondents to the questionnaire were asked to list what they considered to be the advantages and disadvantages of such plans for patients, senior men and assistants. There follows a summary of the responses.

ADVANTAGES TO PATIENTS

Some respondents felt that patients might frequently be able to get appointments more readily with assistants than with senior men. Moreover, they might frequently derive more benefit from therapy by an assistant with supervision by a senior man than from being referred outright to a younger man just starting in practice and working alone. They would have the benefit of having the senior man and the assistant confer with each other and hence of two trained minds and combined opinions instead of just one. Sometimes they would receive better coverage from assistants than from senior men who are likely to be extremely busy with practice and administrative work. If the therapist should be ill or unavailable for other reasons, a patient could be certain of coverage by someone who is familiar with his case. A patient who cannot afford the senior man's private fee might sometimes be treated under his supervision by his assistant at a lower fee.

It was suggested too that sometimes there are advantages to patients to having collaborative, joint or multiple therapists.[1] For example, there may be advantages to having one marriage partner treated by one therapist and the other partner treated by a therapist who is associated with or works closely with the first therapist. The same advantages frequently obtain when one therapist treats a child or adolescent and another therapist treats the parents. Such a collaborative form of therapy can frequently be achieved more readily between a senior man and his assistant than between two colleagues who wish to collaborate but are accustomed to working completely independently. Sometimes one may assume the role of therapist and the other of administrator.

Patients with particular needs sometimes profit by being assigned to an assistant who has different attributes or capacities than those of the senior man. For instance, a female therapist may be indicated for a particular patient.

DISADVANTAGES TO PATIENTS

It was suggested that some patients may feel they are being treated by an "inferior" or "second-rate" therapist when they are referred to an assistant. They may feel they are receiving inadequate treatment under the guise of better treatment. Such patients may feel they are paying for the services of a senior man and are receiving the attention of a junior man. Moreover, patients may resent the fact that part of the fee they are paying goes to a psychiatrist who they feel has not earned it. It was suggested too that acceptance or selection of patients for treatment may suffer in that the senior man may accept some patients realizing that not he but the assistant will be treating them.

There may be "splitting" or dilution of the transference or treatment relationship and complications in identification and in the development and resolution of transference when some patients are treated by assistants, whether or not they are seen by the senior man (well-established conferences between senior man and assistant may help resolve these difficulties). Other difficulties in transference may occur if the senior man shifts patients from one assistant to another.

Sometimes there may be lack of adequate communication between the senior man and his assistant, with resulting confusion of roles and division of responsibility. The senior man and the assistant may each "pass the buck" to the other with the result that neither may actually come to grips with problems. When assistants leave, patients may experience separation anxiety or may be confused as to whether to continue with the assistant, who will now be on his own, to remain with the senior man or to be transferred to another assistant.

ADVANTAGES TO SENIOR MEN

Senior man will have an increased and more steady source of income. By calling on their assistants, they will be able to handle emergencies more effectively, will have greater freedom from unpleasant calls and pressures of practice, and will have more adequate coverage for patients during vacations, illnesses and other absences from practice. They will be more able to take on professional responsibilities outside of practice such as teaching, committee work, etc. Moreover, they will be less lonely in their work. They will derive intellectual and professional stimulus as a result of

[1] See Leo Alexander and Merrill Moore, "Multiple Therapy in Private Psychiatric Practice," *American Journal of Psychiatry*, 113 (1957) 815–23; Don D. Jackson, "The Psychiatrist in a Medical Clinic," *Bulletin of the American Association of Medical Clinics*, 6(1957) 94–100.

preceptoring and from exchanging ideas with young men who have recently received their training. In addition, they may derive some feeling of satisfaction from having assistants.

Finally, having assistants enables senior men to retain the good will of physicians who refer cases to them, when otherwise pressure of work would require them to refuse such cases.

DISADVANTAGES TO SENIOR MEN

It was suggested that the assistants may take too much or too little responsibility, or they may fail to keep the senior men informed about their cases. An incompetent assistant could hurt a senior man's reputation and practice.

One respondent felt that a senior man might feel threatened by his assistant if he himself had gotten behind in current ideas and methods. Others felt that an assistantship arrangement might be too time-consuming if adequate supervision was to be given.

Occasionally it is difficult for senior men to relinquish their assistants as they become more experienced and want to be on their own, and sometimes they find it difficult to let patients go with their assistants when the latter embark on their own practices. It was suggested too that assistants might at times act out in relation to senior men the various transference problems to authority figures which they experience in their training analyses.

ADVANTAGES TO ASSISTANTS

Assistantship arrangements offer an opportunity for assistants to learn about psychiatry and about the business and professional aspects of private practice from experienced senior men. They can gain practical experience without having to carry the full responsibility while still in what amounts to a state of apprenticeship. There are many things about private practice which are not and cannot be taught in residency programs, partly because of some essential differences between the two—for instance, the continued, uninterrupted care, often over a period of many years; greater experience in out-patient work than some residency training centers offer; the opportunity when working in private practice to follow one's patients through a period of hospitalization and thereafter in office practice; the degree of *personal* responsibility for the patient's welfare in practice as opposed to the emotional support that a resident gets from the institution in which he is training; and the extra facilities that private patients can sometimes afford, such as private rooms, outside arrangements with companions, special services, vacations, special diets, etc.

Assistantships offer financial security after residency while assistants are obtaining analytic training or are getting started in practice on the side. Some men who have finished their residency training plan ultimately to move elsewhere to practice but are only part of the way through their analytic training. Therefore, they have no desire to open a practice of their own for two or three years in this particular community and then have to move. Rather, they are interested in a salaried position, such as an assistantship, which will guarantee them adequate security for these two or three years and which will broaden their professional experience at the same time.

Assistants may not only identify to some extent with senior men but may derive confidence and ego-support from working with them. Moreover, they gain a certain amount of prestige because of the reputation of the senior men. They acquire discipline in having to formulate problems for the senior men. They may ultimately re-

ceive referrals in their own practices from patients or from physicians whom they come to know as a result of working with the senior men; and the senior men may recommend them for various positions during the ensuing years as a result of their having worked together.

DISADVANTAGES TO ASSISTANTS

It was suggested that there may be limitations to the assistant's freedom, and that assistantships constitute a sort of "second-class citizenship." Sometimes there may be absence of sound teaching or adequate supervision or there may be lack of communication of information about patients by senior man to assistant. Sometimes too the senior man may delegate too much or too little responsibility to the assistant. If the senior man is too controlling, the assistant may not develop a desirable degree of initiative and independent judgment, and he may tend to become a permanent "second man."

Occasionally assistants experience feelings of resentment against the senior man, possibly because they do not feel they receive as much income from patients as they deserve or in other instances because of transference feelings.

One respondent felt that an assistant might have to treat patients whom he himself would refuse to treat or might have to treat patients in a way in which he would not treat them under other circumstances. It was suggested too that having been an assistant might cause people during later years to think of the younger man as still being associated with the senior man as his assistant when actually he is now on his own. Therefore, some patients might not be referred to him who actually would be, if other people knew he was conducting his own practice.

COMMENTS AND CONCLUSIONS

It is the authors' belief that whether assistantships are helpful and satisfactory for patients, for senior men and for assistants depends in large measure upon the points of view and attitudes of the senior man and his assistants. If the welfare of all concerned and particularly that of the patient is kept constantly in mind, such arrangements will work; if not, they will fail to some degree in one respect or another. There must be a flexibility and an ability to see the other person's point of view. For example, the senior man must recognize the needs of his assistant—whether the latter be needs for dependence and supervision or for an increasing degree of independence and responsibility. The authors realize that there can be pitfalls to such arrangements but believe that if the senior man and the assistant are aware of them, if they discuss them openly and together decide how to avoid them, the best interests of everyone can be served.

The similarity to the father-son relationship, the mother-son relationship (transference of dependency, for example) and sibling relationship may create problems in the relationship of senior man to assistant. The success or failure of the lines of communication and cooperative approach to patients and the over-all state of "health" of the practice may ultimately rest on the cathexis which the senior man has, not only in his patients, but in his assistant and also on the cathexis which the assistant develops in the senior man's practice. The absence of such cathexis tends to lead to unnecessary sibling rivalry between assistants, and to hostility between assistant and senior man, with consequent acting out of power-struggles in various ways. When on the other hand the senior man, as the "good parent," cathects the assistant as well as his practice, he automatically helps the assist-

ant with the management of cases and with professional growth and development.

It has been suggested that the word "associate" should be used instead of "assistant" inasmuch as it presents the junior man as more of a colleague, increases his sense of importance and self-assurance and leads to a greater feeling of confidence in him on the part of the patient. (In this paper the word "assistant" has been used intentionally for the sake of clarity.)

It is believed that a plan which permits the assistant to have increasing amounts of time for his own practice each year will lead to fewer difficulties and will foster his ultimate emancipation.

It is important that the arrangement be free from any implication of fee splitting. Among other things, this means that patients should know that they are being treated by an assistant on the senior man's service and that the billing will be done by the senior man.

In conclusion, it is hoped that this report will be helpful to those who are involved or who may become involved in such arrangements, either as senior men or as assistants.

SUMMARY

Based on the personal experience of the authors and on information derived from questionnaires which were received from 100 psychiatrists throughout the country, a report is presented on the advantages and disadvantages of arrangements involving the use of assistants in the private practice of psychiatry. The reactions of the respondents indicated considerable divergence of opinions. On the whole, however, there was greater expression of favorable than of unfavorable opinion.

Detailed advantages and disadvantages to patients, to senior man and to assistants are cited. The authors' arrangement is described, not with the idea of its being the ideal plan for other people in other situations but to illustrate the details of at least one type of arrangement. Other arrangements are mentioned briefly.

The authors believe that when an assistantship is carefully conceived and when it is put into operation with proper attention to such matters as supervision and the dynamics of a complicated professional interpersonal relationship, the advantages to patients, senior men and assistants outweigh the disadvantages which may still exist.

MARTIN L. NASS, PH.D.

Characteristics of a psychotherapeutically oriented group for beginning teachers

The purpose of this paper is to present a report of the findings of a 1-year pilot project conducted at Brooklyn College for newly-appointed elementary school teachers who had received their undergraduate teacher training at the college and who were at the time of the project engaged in graduate study in the teacher education program. The project was conducted by the writer, a clinical psychologist, in the setting of the Educational Clinic, which is an adjunct to the teacher education program.

The project was established with several purposes in mind. The primary aim was to afford a group of beginning teachers an opportunity to meet with a clinician to discuss such problems of adjustment as they might experience in the school situation. It was expected that these would include problems with relationship to colleagues, children and supervisors. It was anticipated that the clinician would attempt to help the teachers formulate and clarify such problems with respect to their own role as teachers, and thus help establish a more objective basis for classroom behavior. The project was also viewed as a means of providing the teacher training institution with a greater insight into the needs of the prospective teacher with a view toward more effective accommodation of these needs.

The recent literature is sparse in reports of similar types of studies. Berman (1, 2) worked with a mixed group of educators in the Boston area over a 15-week period in an attempt to improve the functioning level of the individual through increasing his understanding of himself, his students and

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his colleagues. The approach was a combination of group psychotherapy and educational techniques, and the group contained people of varying ages and backgrounds. The data were considered both in a teaching context as well as in a psychotherapeutic vein.

Buckley (3) met with 8 teachers of varied age, experience and background in a group psychotherapy situation. He reports positive results in terms of certain objective criteria and indicates the beneficial nature of the program to the people involved. During the course of his program, contact was maintained with the schools and supervisors of the group participants and the reactions of the supervisors to changes in the job performance of the group were obtained.

Further descriptive reports of similar types of studies are not available. However, several investigations regarding interpersonal problems faced by teachers have been reported. Thus, Jersild (5) in a survey of over 1,000 teachers and graduate students found that an overwhelming proportion of them felt the need of self-understanding in order to facilitate growth, and advocated some kind of group experience in an educational setting. "The teacher's understanding and acceptance of himself is the most important requirement in any effort he makes to help students to know themselves and to gain healthy attitudes of self-acceptance." [1] Glidewell (4) in a role-playing situation, found that teachers' effectiveness as leaders increased when group members were able to express and accept their feelings. The major concerns of a group of 120 student-teachers was investigated by Travers and others (7), who found that the two primary concerns of the group were discipline and the desire to be liked and accepted by their students.

PROCEDURE

A letter describing the purposes of the project was sent to 100 early childhood and elementary education graduates who had completed their undergraduate degrees within the preceding year, who were enrolled in the 5th-year teacher education program, and who were currently teaching in the New York City public schools. Ten affirmative replies were received requesting further information and interview arrangements. During the process of screening, two individuals dropped from the project prior to the interview. The remaining eight were interviewed individually to evaluate such factors as awareness and acceptance of individual problems, ability to express feelings, and motivation for applying for the group. The nature of the project was described to each applicant and the confidentiality of material was stressed. As a result of the interviews it was decided to exclude two individuals because of their failure to meet the criteria for admission. The remaining six, all of them women, proved to be interested persons who were well motivated toward clarification of their school problems. Two of the six were kindergarten teachers; the remainder taught at the elementary level.

The group met over the period of one year for 32 sessions of one and a half hours each. While the project had originally been established for one semester, the group unanimously requested an additional semester of meetings. Supervision of the psychologist was given by the clinic psychiatrist on the basis of one hour per two group meetings.

At the beginning of the program the teachers were told that the content of the

[1] Jersild, A. T., *When Teachers Face Themselves.* New York, Bureau of Publications, Teachers College, 1955, 3.

sessions was up to them, and that a minimum of direction would be given. The role of the group leader was primarily one of identifying underlying attitudes of the participants and using them as a basis for discussion.

RESULTS

The kinds of problems discussed in the meetings have reflected the universality of some of the difficulties facing the new teacher. Four of these areas will be discussed. They are the teachers' relationships with authority, their expectations of themselves as teachers, their relationships with colleagues, and their relationships with children.

RELATIONSHIPS WITH AUTHORITY

Evidences of authority problems have appeared throughout the course of the meetings, although the content, direction and expression of these problems have changed markedly. This has been noted both in the group's behavior toward the leader, as well as in the content of the material presented.

The group's identification of the leader as a member of the faculty and as a representative of authority in the college has become evident on several occasions and has been discussed as a factor inhibiting group movement. Despite the reassurance of confidentiality, it took a good deal of time for the group members to accept the fact that they would not be reported to college or school authorities or to their instructors for their feelings.

The group members have been unanimous in their conception of authority as critical, hostile and destructive. These attitudes have appeared particularly in relation to supervisory evaluations. On one or two occasions their attitudes had a strong basis in reality. Most frequently they did not. Teachers who received glowing supervisory reports entered the conference with the fear that they were about to be dismissed.

Another area involving authority problems was that of parent-teacher contacts. Group members were initially quite frightened of any kind of contact with parents, fearing criticism and being reported to higher authorities. This came through most strongly during Open School Week, when parents visited the classrooms. The teachers felt that they were being observed through a critical eye, and that the parents were more concerned with the teachers' performance than with that of the children. The problem was further contaminated by the fact that in two situations the teachers' own mothers visited their classes during Open School Week.

Within the group setting, some of these attitudes have been traced to material outside of the school situation, particularly with respect to earlier attitudes toward parents and teachers. The teacher whose authority problems seemed most severe was one whose experiences with childhood authority had been critical and punitive and who was helped to recognize the similarity between the early and current situations. In addition, the fact that other people in similar situations shared similar kinds of feelings served as a reassuring mechanism, thus permitting more open discussion of these kinds of problems within the group.

As a result, authority problems did not come through in as severe a manner in later sessions as they did in the earlier ones. The focus of the problem seems to have shifted from "What does the authority expect of me?" to "What factors are inhibiting most effective classroom performance?" In this area, as in other areas of group consideration, the group has moved from seeking to obtain prescribed solutions to problems toward gaining increased understanding of

the factors involved in the determination of a given attitude or reaction.

EXPECTATIONS OF SELF

Generally speaking, the newly appointed teacher feels that unless she achieves perfection in all areas of functioning, she is a failure as a teacher. This has been consistently true with respect to material which has been discussed in the group.

In the first session one of the members described her difficulty with an extremely disturbed child who had problems in accepting limits. The feeling expressed by the teacher was that unless this youngster became an integral member of her class, she had failed in her duties as a teacher. When the more realistic factors of the situation were discussed and the fact became known that this youngster had a long history of emotional disturbance and school difficulty, it became apparent to the teacher that she was using this situation as a test of her own adequacy.

During the tenth session a similar situation arose with respect to this same teacher. It was apparent, from her knowledge of her class and from information given to her by supervisory personnel, that her class, from an intellectual and achievement point of view, was inferior to the other classes in the grade and had been organized in that way at the beginning of the school year. At the time of the city-wide achievement survey she expressed the feeling that unless this class compared favorably with the others in the grade, poor teaching ability on her part would be revealed. When the unreality of her expectation was pointed out to her by the group, she saw that this was another situation which was set up by her in terms which were impossible to realize.

When this same person brought up an analogous situation with respect to an overly demanding parent in a later session, she herself said, "I suppose that what I'm expecting is out of line with what is actually going on."

This type of attitude has been generally true of the other group participants, and similar kinds of movement have been noted. One of the teachers commented on the importance of "looking at yourself first" when dealing with a problem to determine if the expectations have a realistic basis. In the meetings the majority of the group began to deal with discussions of problems from this point of view.

RELATIONSHIPS WITH COLLEAGUES

The group has also been a valuable medium for studying the teacher's relationships with colleagues, as manifested both in the school situation and in the group itself.

The problem, as it initially emerged in the first few sessions, took the form of constant comparison between themselves and more experienced teachers in their schools. This comparison ignored the experience differential and seemed to be used as further proof of their inadequacy. Thus, in the third session, when discussing the problem of group control, a group member compared her "discipline" unfavorably with that of another teacher in her school. Subsequent discussion indicated that the teacher in question had ten years of experience in the classroom.

In later meetings this problem was dealt with in terms of their conceptions of their roles as teachers. They considered materials relating to their early experiences with teachers as well as their perceptions of teachers' roles. One member of the group reported that she had always regarded teachers with awe and considered them superhuman. When placed in this role, she considered the other people in her school—that is, the "older" ones—as teachers, but

viewed herself as never being able to measure up to her childhood image.

Thus, it has become apparent that the beginning teachers in our group have viewed themselves, in terms of role, as being closer to the children than to the more experienced teachers in the school. In one instance a group member found herself having her former fourth grade teacher as a colleague, thus intensifying the problem from the reality point of view.

RELATIONSHIPS WITH CHILDREN

The aforementioned feeling of being closer to the children than to other teachers also manifests itself in the classroom problems of the new teacher. This has shown itself on several occasions. For example, in the fifth meeting one of the members described her difficulty in having her kindergarten group clean up following an activity period. The ensuing discussion brought out the feeling that "it isn't fair to have them do the dirty work." What became apparent was an indication that the teacher assumed that the children felt the same way about cleaning as she did, and that if she made this demand they would no longer like her. Subsequent to this session, the teacher reported that she discovered that the children actually enjoyed cleaning up and that it had been her attitude that she had attributed to them.

On a more general level it was clear that the group initially felt that it was essential to be liked by the pupils. Interpretation of this attitude by them brought about the realization that they experienced difficulty in setting limits for the class. They feared that setting limits would complicate their relationships with the children. It has become increasingly apparent to them, however, that their position reflected both their needs and their distortions of the problem and did not represent the needs of their youngsters in the classroom setting.

DISCUSSION

In this pilot project the feelings and attitudes of a group of newly appointed teachers were identified and explored through the medium of a psychotherapeutically-oriented approach. From the data obtained, it is evident that such a program requires the leadership of a clinically-trained individual as well as competent supervision, since phenomena of relationship common to other kinds of psychotherapies—for example, transference reaction and resistance—are present and must be dealt with therapeutically in order not to impede group progress.

Our results strongly suggest that many of the problems which manifest themselves in the classroom are reflections of more basic personality factors and that examination of these factors and the resulting increased awareness serves as a basis for growth and self-understanding.

Many of the diverse problems discussed by the teachers and presented here have their roots in basic problems of conscience. The teachers' strong burden of guilt and low self-esteem seemed to becloud their perception of reality. Thus, in one situation the teacher experienced excessive demands on the part of her supervisor; in another situation she made these demands on herself; and in a third situation she felt the children were requiring more than she was able to give them.

The participants in this project have reported it to be a valuable experience, not only helping to increase their classroom effectiveness, but providing insights into relationships outside of the school situations.

Due to the small size of the group and sampling limitations, the project will be repeated in the near future with another group of teachers. If the results are similar, it is anticipated that the materials will be used as a basis for discussion with teacher

training personnel to help them gain increased insight into the emotional problems of the beginning teacher.

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Social and emotional development of students in college and university

Part 2

INTERNATIONAL INTEREST IN MENTAL HEALTH OF STUDENTS

That interest in the social and emotional development of students in college is strong in other countries of the world was amply demonstrated in September 1956, at Princeton, N. J. At that time the International Association of Universities and the World Federation for Mental Health united in sponsoring a 10-day conference, attended by 37 delegates from 10 countries, at which all the major issues confronting colleges and universities in the field of mental health were reviewed, some of them in considerable detail. The Grant and Field Foundations gave financial support, the chief executives of the two sponsoring agencies, as well as the executive directors of the foundations, attended the conference, and the writer of this report was the conference chairman. Delegates included educators, deans, chaplains, psychologists, students, public health experts, psychoanalysts and psychiatrists. The countries represented were Costa Rica, Mexico, Australia, Malaya, the Philippines, France, Holland, Great Britain, Canada and the United States.

Dr. J. R. Rees, director of the World Federation for Mental Health, had long been working to organize such a conference, but support was lacking for a number of years. He thought that recommendations

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concerning mental health programs coming from the United States alone would not be received elsewhere with as much attention and receptivity as those emanating from an international conference, largely because of the universal tendency to assume that only the United States has financial resources sufficient to carry out such programs.

PURPOSE OF CONFERENCE

The conference was organized for the purpose of exchanging points of view of workers in different cultures, countries and types of educational institutions. A still more important reason was to determine whether there were any common principles or kinds of programs which would be recommended to educational institutions in all countries.

WHAT MENTAL HEALTH IS NOT

At the end of the ten days of exploration of the issues and problems involved, the delegates to the conference believed that enough general agreement had been achieved to permit the issuance of certain general recommendations to educational administrators and planners in all countries. Preceding these recommendations it was thought desirable to make it clear that although mental health cannot be defined in a simple universally acceptable manner, it is possible to make some clarifying negative statements about it. It was unanimously agreed that mental health is not characterized by adjustment under all circumstances, nor by freedom from anxiety and tension, nor by freedom from dissatisfaction, nor by conformity or constant happiness. Furthermore, the possession of mental health does not mean the absence of personal idiosyncrasies, a lessening of accomplishment or creativity or the undermining of authority, and it is in no way opposed to religious values.

RECOMMENDATIONS TO ALL COLLEGES AND UNIVERSITIES

The recommendations or resolutions may be summarized as follows:

1. The promotion of mental health in colleges and universities is the concern of every person connected with these institutions. The problem cannot be solved simply by supplying the counseling and psychiatric needs of some of the students, but rather by maximizing those factors within the institution which allow each student to reach his greatest potential growth, both academically and as a human being.

2. A mental health program should be geared to the usual educative processes of the institution. It may include service functions and teaching and should involve both faculty and students.

3. Training programs should be established in various countries, adapted to the special needs of the area in which they are located.

4. Special attention should be given to students who fail to complete their formal education, as well as those threatened by failure for emotional, social or cultural reasons.

5. Guidance programs of secondary schools and similar programs in the colleges should be more closely integrated in order to avoid sending out into the community so many embittered and frustrated persons who feel rejected by society.

6. By a variety of means, instruction in marriage and family living should be available to all students.

7. Research should be an integral part of all mental health programs.

8. Educational administrators, faculty members and students should have some awareness of the kinds of alterations of behavior

and thought in any given society or culture which indicate serious emotional disturbance requiring professional attention. Achievement of this goal requires a very tactful, thoughtful and widespread educational program.

9. Opportunities should be made available for faculty members to acquire the basic concepts of personality functioning that broaden understanding of the learning process and increase ability to aid the student in his intellectual and emotional development.

10. Factors in educational institutions that foster undue dependency, both those of environmental as well as those of inner psychological nature, should be studied continually.

11. Student responsibility for their education and conduct should be encouraged within limits, and the views of students should be heard and considered by faculty and administration.

12. Special attention should be given the lonely student although it is recognized that the student who prefers solitude is not a proper object for concern.

13. Special attention and study of the needs of the young married students is desirable.

14. Proper housing and other environmental needs are appropriate subjects for consideration by college and university planners.

15. The conference delegates deplored the development of curricula so crowded by formal studies, particularly in professional schools, that no time is left for participation in activities making for a well-rounded educational experience.

16. It is an important principle of mental health that all human beings, regardless of sex, race, color or religion, be treated with equal dignity. Total discrimination on the basis of race, color or religion injures both those rejected and those in the institutions that practice such policies.

17. Severe overcrowding of college or university facilities produces serious psychological problems for many students. This is a very delicate problem, but a rapidly growing one.

All deliberations of the conference were recorded, and the material has been summarized and edited. This, together with selections and digests from about 30 papers submitted by the delegates prior to the conference itself, was published in the fall of 1959.[1] This volume should be most useful in stimulating interest in this field as well as in developing an increased awareness of how complicated and subtle is the problem of developing better mental health on a large scale.

POSSIBLE FUTURE DEVELOPMENTS

Future trends in this field seem to be discernible at the present time. There is a gradually increasing interest on the part of college presidents, deans and educators in teaching faculties about these emotional factors that accelerate or impede learning. There is increasing dissatisfaction with reliance on types of counseling that are confined largely to course information, career choice and testing for appitudes or intellectual capacity, even though these activities are valuable and necessary. The need for applying knowledge gained from the newer studies in personality growth and development, as well as the consideration of factors which cause students to become ill and in-

[1] Funkenstein, D. H. (ed.), *The Student and Mental Health—An International View.* New York, World Federation of Mental Health, 1959.

effective academically, is becoming apparent to many educators. But how to apply this knowledge remains still an unsolved problem.

MANY DISCIPLINES INVOLVED

Many disciplines besides psychiatry have something to contribute to the solution of the task of integrating a consideration of motivation, emotions, unconscious factors and related matters into the traditional educational program of institutions of higher learning. The proponents of religion may assert that all would be well if only we would all believe as one. The anthropologists, the sociologists, psychologists and professional counselors all have much to offer. The educational psychologists, the psychoanalysts and the experts in human relations have definite and valuable ideas on what might be done. Clearly, some central concept or base of operation would be helpful.

Speaking as a physician who has worked in this field over a period of more than two decades, I believe that there are a number of possibilities, all dependent more on the interest, personality, training and capabilities of the individuals influential in the programs than on the particular system or scheme of operations. I have found that when the impetus for a mental health program comes from the health service, through its psychiatric division, and is wholeheartedly supported by the dean's office and other members of the college administration, the necessary coherence can be attained. My opinions will be based on my experience with this type of organization. At the same time, I am aware that other approaches might be equally practicable.

The approach to making college a more meaningful part of the student's life and to creating conditions that encourage the development of mature attitudes is by setting up focal centers in each of the institutions that desire it—a small group of persons who see what issues are at stake and who will form the nucleus of a permanent in-service training program for all faculty members. Most members of such a group are already present in any college. The dean of students, the director of admissions, the director of the health service, the college chaplain and the chairman of the faculty committee on counseling are among the obvious choices for membership in such a group.

But these are not enough. The group needs one or more professionals, depending on the number of students, to give the needed emphasis to those many and varied aspects of individual behavior which have in the past been assumed to lie outside the scope of formal educational procedures. Assuming that this person is a psychiatrist, his work will consist in part of seeing individual students who are faced with personal problems, but more importantly in the long run he will consult with many other members of the college community, help in the resolution of educational dilemmas, and stimulate the interest of all who may have a latent curiosity about personality development. He will attempt to further the development of improved attitudes through group discussion, suggested reading of books and articles, and innumerable informal contacts of a casual nature.

Each college should work out its own program in terms of its resources, available personnel, needs, location and educational goals. The unifying factor of a body of theory and practice is rapidly being developed and will serve to keep individual colleges from getting bogged down in generalizations or from developing programs so diffuse that the participants do not know what they are doing.

Many colleges are now ready for such

a program and would encourage and support it. The limiting factor is the shortage of suitably trained psychiatrists, psychologists and social workers, particularly the former. On the other hand, many young psychiatrists are showing great interest in college psychiatry as a career, either on a full- or part-time basis. They need training and experience in this special field. Their stage of maturity and professional development is such that they cannot pay for this training, especially in view of the relatively limited financial return that they must anticipate from any educational institution after they assume their permanent positions.

TRAINING PROGRAMS

The greatest need at present is the development of training programs for young psychiatrists, clinical psychologists and social workers who wish to enter the field. Several universities in the United States have developed psychiatric services as part of their health programs which are sufficiently effective and accepted to serve as training centers. Among these are the Universities of California, Wisconsin and Minnesota, the Massachusetts Institute of Technology, Yale and Harvard. Other institutions that are laying the foundations that could serve as possible training centers in the future are Cornell and Columbia Universities, the University of Pennsylvania and the University of Chicago.[2]

The large universities that are prepared to set up suitable training programs cannot afford to develop adequate centers without outside financial support. Supervision of trainees is expensive and should not be casually attempted. Combining the resources available for psychiatric treatment of their students, usually derived from health service fees, and grants-in-aid to train young men and women in this field would result in advantages both for the training institution and those colleges which would later benefit from the experience of the trainees.

PROFESSIONAL SCHOOLS

Coincidentally with the setting up of training programs in large universities and groups or divisions in the colleges that emphasize the social and emotional factors in students that promote integrity and maturity, some attention should be paid to the further development of theory in this field. A number of well-known and experienced older persons of great professional skill are available and eager to do this if they can have the necessary support. The dynamics that are involved in the development of the late adolescent and young adult form one interesting and vital area for extended study and research. The role of psychiatric ideas in the improvement of educational procedures is another field much in need of elucidation.

Another need which is closely related to the establishment of training programs is the development of combined programs of demonstration and research in a few institutions, designed to try various procedures which give promise of promoting better trained and more mature graduates. Among the procedures which should be tested for possible effectiveness are group discussions designed to bring out the varying ways by which strong emotions are expressed or affect behavior. How this idea might be explored we may describe in terms of a professional school curriculum, using a law school as an example.

Let us suppose that in this law school

[2] Farnsworth, D. L., *Mental Health in College and University*. Cambridge, Harvard University Press, 1957, 173–80.

there are a very considerable number of persons who are vaguely dissatisfied with the results of three years of legal training on the students and who believe that a greater knowledge of personality factors of their clients and of themselves would help the students to become better lawyers. Arrayed against those who are discontended with the curriculum are a still larger group who believe that no changes are necessary, that the law should not become involved in matters of personality, that psychiatry cannot be a science since its borders and functions are so ill-defined, and that the thinking of modern dynamic psychiatrists is destructive of the legal process. Some faculty members may even say that since areas of common concern to the physician or psychiatrist and the lawyer form such a small part of legal education they may be safely disregarded.

The members of the group in the faculty who would like to see some of these problems explored learn that many students feel as they do about their training. They are concerned because so many students need individual psychotherapy to enable them to cope with the stresses they encounter in the school. Small groups get together and explore their common interests. They look for help but find that this is largely an unexplored field. They consult with the deans of the school and find that they too are concerned and willing to follow up the matter more intensively. They learn that many law students are seeking psychiatric help and that certain kinds of personality disorders seem to be more prevalent in law students than in those from other schools.

A young, well-trained psychiatrist is then found who comes to the law school as a member of the faculty and of the health service. He is not required to take on all students and faculty members as patients who may wish his services. In fact, he is discouraged from doing so. Those who wish individual therapy may go to the health service psychiatrists or to private practitioners. He may do some individual treatment in some other setting than in the school itself in order to avoid loss of skill in this area.

During the first year, he studies the school and its curriculum, attends some classes, becomes acquainted with faculty members and student leaders, takes part in seminars or class discussions when invited to do so, tries to learn what the main sources of tension may be, and meets with any groups who may call on him for consultation. When he meets opposition he tries to understand it, learns from it when possible, and respects it, but does not protest in return. He works in close harmony with those psychiatrists who serve the community but does not get involved in patient-psychiatrist confidential relationships that would impair his usefulness in the law school.

Soon he finds that various groups of students would like some systematic consideration of the issues involved in human behavior when questions of criminal responsibility arise. Younger faculty members likewise have their interest stimulated. A few faculty wives may wish to organize an unofficial seminar on mental health problems. Consultants from other schools who have had different kinds of experience in the same field may be invited for a discussion of possible new developments and a comparison of results.

The direction such a program would take is unpredictable other than to say that it would undoubtedly lead to a reconsideration of many questions of vital importance in interpersonal relationships. Its success would depend in large measure on the attitude, skill, ingenuity, imagination and enthusiasm of the psychiatrist in charge.

In other professional schools modifications would be desirable consistent with the characteristics of the type of education desired. In at least four theological schools—Yeshiva University of New York, Loyola University of Chicago, Harvard Divinity School and Union Theological Seminary—programs are just beginning which are designed to explore the methods by which religion and mental health, or psychiatry, may collaborate effectively. Such cooperation is planned with the hope that graduates of these institutions will become more effective ministers than they could be without the skill and knowledge which can be derived from the study of mental health principles. Each of these projects is headed by a theologian or a psychiatrist with a member of the other profession as associate director. One project is supported by a private foundation, the others by 5-year grants from the United States government through the National Institute of Mental Health.

The Association of Medical Colleges is giving intensive consideration to the individual problems and development of the medical student. Counseling and tutorial programs are being examined with the view to vitalizing them by new concepts gained by recent studies of how students may be motivated most effectively.

Engineering schools, notably the Massachusetts Institute of Technology and California Institute of Technology, have been devoting major efforts to counseling programs, health services, psychiatric services, improvement in course offerings in the humanities and social studies, and student-centered activities (athletics and student government) all designed to produce graduates more mature and responsible than if they were simply well versed in mathematics, the sciences and engineering.

TESTS OF MOTIVATION AND VULNERABILITY

If the general feeling and opinion of college psychiatrists that unsatisfactory family relationships and poor environmental conditions are important causes of illness and failure in college students, some methods should be devised to identify such individuals early in their college careers. This is especially true if such handicaps can be removed by individual counseling or psychotherapy. These students should be identified after their admission and appropriate measures should then be instituted, but they should not be screened out because of the existence of untoward family relationships. Many of our most productive citizens and most capable students have come from backgrounds with many presumably harmful features, but by a variety of circumstances they have reacted to such stressful situations by effective adaptations. Unfortunately, many more who are equally capable encounter circumstances more adverse than they can contend with successfully. Research to design appropriate tests for finding those most likely to be aided by individual attention is urgently needed.

When should a mental health program be expected to produce optimum results? Perhaps the beginning should be made in the kindergarten or in prenatal clinics with expectant mothers, or even in the late years of secondary school. Any argument as to which age is best for a beginning is rather pointless because from the practical point of view attention to mental health is needed at all levels of development. College students are in an excellent position to profit from a consideration of factors promoting mental health since they are confronted with so many possibilities and choices whose wise resolution is of utmost importance to them. They are also at the stage of either

having recently become parents or are in the process of selecting a marriage partner and hence have much potential interest in the conditions that favor the development of sound and healthy children. A college mental health program is easily integrated with other parallel programs at any stage of life.

NEW AND PROMISING EXPERIMENTS

The experience of the 420 students who were admitted to colleges with only two or three years of high school in 1951 under the auspices of the Fund for the Advancement of Education illustrates the fact that radical experimentation in varying educational procedures may be done without endangering the social or emotional adjustment of students, and may even facilitate their growth and development. These students were from one to two years younger than their classmates. They were admitted to 11 colleges widely differing from one another. They encountered expectations on the part of many faculty members, administrators and others that their age and social inexperience would produce a higher proportion of difficulties in terms of adjustment than in the rest of the student body.[3]

The entire group was investigated by psychiatrists who spend most of their time caring for the mental health of college students. The findings in the 11 colleges had numerous variations, but there was similarity in the fact that the students admitted early had no more psychiatric problems than their controls or the general student body. In most instances the percentage in this group experiencing difficulties was smaller than in the other groups. Psychoses occurred quite infrequently and from causes not dependent upon early admission. The test group made no more visits to counseling services than were made by comparison students. Visits to the medical services were no more numerous than by other students. The group was no more "emotionally immature" than their classmates, and their rate of failure was lower than that of the comparison students or of the student bodies generally.

In general, the students admitted early desired counseling services on an individual basis, but resented any procedures that differentiated them from their classmates. They did not want any special treatment that set them apart. The only disadvantages they experienced had to do with dating for the boys and obtaining summer employment for the girls. A large number of these students felt that they had been favorably influenced in their social and emotional development and that they had escaped the harmful effects of boredom from lack of intellectual stimulation.

The Advanced Placement Program[4] is another experiment among those designed to loosen the hold of tradition that might be detrimental to educational procedures in this country. In this plan work is done at the college level by some of the more able secondary school seniors, examinations are given by the colleges, and the successful student is then granted credit for the courses thus completed when he enters college. The plan is steadily expanding. It has been helpful to students in keeping them working more nearly up to their capacity; their intellectual motivation is increased, and they get on to advanced college work sooner. To the teachers involved, both those in the secondary schools and in the colleges, new ideas and enthusiasm are generated, and the work of the schools and colleges has become better integrated with less duplication of

[3] *"They Went to College Early."* New York, Fund for the Advancement of Education, 1957, 46–59.

[4] Keller, C. R., "Piercing the Sheepskin Curtain," *College Board Review*, Fall 1956, No. 30.

effort. The movement is in the direction of stressing the individual and is thus a desirable counterpoise to the growing pressures toward quantity production in education.

NEW DIMENSIONS IN HIGHER EDUCATION

All these considerations confirm only too well the fact that those who are in positions of responsibility for planning the future of higher education in the United States are faced with many complex problems, some of them seemingly contradictory. They have too many young men and women to educate and too few teachers and facilities to do the job satisfactorily. Either new methods of teaching must be developed and new types of relationships between teachers and students encouraged, or rapid deterioration of the quality of college teaching and learning will follow. Emphasis on better salaries for faculty members and on building new classrooms and laboratories is necessary but, desirable as these goals are, even if won they will not solve many of the problems of higher education. Something new is needed, and urgently.

A new approach to the problem of higher learning in America will have influence on education all over the world. It is therefore exceedingly important that any concerted move made in American education be planned in such a way that adaptation to other societies and cultures be possible.

The new dimension of higher education that I consider to be in most urgent need of exploration is that of the role of emotions in education. One of the ubiquitous problems in relationships between individuals, between states or nations, and between races is that of the handling of hostility in such a manner as to avoid purposeless and chaotic destruction of human lives, and to develop instead attitudes of cooperation and reason. This can be done on a mass scale only by working through groups that are sensitive, influential and responsible. No more suitable group can be found than the large—but, statistically speaking, relatively small—segment of our population engaged in higher education. This includes both students and teachers. If their thinking is broadened and enriched by any new development, the attitudes of alumni of the various institutions will also soon be altered.

At the present time more than 3,600,000 students are enrolled in our institutions of higher learning. More than 42,000,000 young people are in our schools of all grades or levels. There are about 1,200,000 teachers in all our schools. Among the professional groups that keep in some communication with what is going on in our schools are 240,000 physicians (of whom only 10,000 are psychiatrists), 200,000 lawyers and 325,000 ministers. Any new and constructive move such as I have described that meets with the support of the majority of persons engaged in these broad fields of endeavor will very soon be reflected in altered attitudes, methods and procedures in the entire country.

The size of the task appears overwhelming, but the need for its accomplishment justifies an attempt by all the resources at our disposal.

ARTHUR L. BEELEY, PH.D., LL.D.

Alcoholism, social work and mental hygiene

When we say that alcoholism is an illness, do we imply that the "illness" can be the illness only of a person? Is it not possible that a society also can be ill?

I shall argue that alcoholism can be both the illness of a person and the illness of a society. There is a valid axiom of social psychology which aptly describes the relationship of the individual to his cultural group, as subject and as object. The inseparability of these two facets is suggested by the metaphor that they are like the two sides of a coin. This principle is tersely expressed in the intriguing title of a recent book, *The Juvenile in Delinquent Society* (1).

A few months ago I spent some time in New York City observing at first hand the activities of the New York City Youth Board and discussing the evaluation of its activities now being made by Dr. Robert M. MacIver, a distinguished sociologist of Columbia University. He said the board had just completed a study of juvenile delinquency among Puerto Ricans, and had found that it is 12 times greater in New York City than on the island of Puerto Rico itself! Can society be sick? Yes, indeed. And if our logic is sound and our assumptions correct, sick societies produce sick people.

In our past and present thinking about human behavior we have been too greatly influenced by two general ideas: first, the belief in a free will; and second, the prepotence of heredity. Even today most people only grudgingly admit the influence of environment and of our social institutions

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upon personality and character. This influence, sometimes for good, sometimes for ill, is apparent to all unprejudiced observers. It is also an axiom of social psychology that one of the major factors in social disorganization is the accelerating tempo of social change, especially as seen in large industrialized centers which intensify anonymity in human relationships.

At this point let me call attention to two books which amplify the view I am here advancing. The first is a study by Frank, a distinguished group therapist, entitled *Society as the Patient* (2). The other is a more recent book by Fromm, a psychoanalyst, *The Sane Society* (3), in which he discusses the pathology of normalcy, the roads to sanity, etc.

Perhaps the most convincing study which has appeared since World War II is the epidemiological survey made by the Scottish psychiatrist, Halliday, whose brilliant researches are reported in *Psychosocial Medicine* (4). He considers Great Britain as a "sick society," as evidenced by the recent phenomenal increase in the "psychosomatic affections." As a result of his intensive study of the coal-mining community in Britain, he thus proves his thesis convincingly.

But you might ask at this point: Are you trying to argue that sick societies intensify the problems and consequences of alcoholism? Yes, indeed. Moreover, I am convinced, *a priori*, that if we made extensive epidemiological studies in this country, of the sort made by Halliday in Britain, we would discover an equally sharp rise in the frequency and extent of psychosomatic ailments in the general population and an even sharper rise in the pervasiveness of addictive alcoholism.

LANDMARKS IN SOCIAL MEDICINE

Permit me at this juncture to make a brief detour and to share with you some ideas which have formed part of my lectures to medical students at the University of Utah. Knowing how hard-pressed the average medical student is to find time for outside reading, I first call his attention to two unusual books, both written by eminent physicians. The first is *Civilization and Disease* by Sigerist (5), a genuinely profound study. The second is an equally brilliant study by Cobb, *Borderlands of Psychiatry* (6).

In his monograph—a superb manual not alone for the professional, but for the quasi-professional worker as well—Cobb points out that the hard core of psychiatric medicine comprises the approximately 700,000 hospitalized patients suffering from mental disease; and the approximately 100,000 institutional cases in the mental defective population in state schools. On the periphery of this institutional problem are some 3 to 5 million "dements" and "aments" who are unhospitalized. On the borderland of these problems, however, are the less serious but more frequent mental illnesses known as the psychoneuroses, epilepsy, stammering, alcoholism, etc.

Cobb conservatively estimates that in 1943 some 1,600,000 men and women in the United States were definitely "injured" by alcoholic intoxication. These are the people, he says, who can neither get along with liquor nor without it. A revised estimate, using Jellinek's formula, however, indicates that Cobb's estimate is altogether too conservative. In 1955 it was estimated that there were 4,712,000 alcoholics in the United States—4,002,000 men and 710,000 women—giving a sex ratio of 5.6 to 1. This is an increase of 50% since 1940 (7).

My chief point in addressing medical students, however, is to indicate the historical landmarks in social medicine. There is an ancient belief which has persisted for centuries (and is still naively believed by many today) that the human organism is like a

machine; and that if the body fails to function properly, the cause must perforce lie inside the body. In speaking of the relationship between mind and body, the field now known as psychosomatics, Cobb quotes from the dialogues of Plato in 380 B.C.: "For this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body." It was not until the beginning of the 20th century, some 2,300 years after Plato, that many human maladies, including certain mental disorders such as those which Cobb lists as "borderland" (for example, alcoholism), were forthrightly regarded as psychosomatic in nature.

Another landmark in social medicine was achieved in 1909 when William Healy, a neuro-psychiatrist, organized the Juvenile Psychopathic Institute in Chicago as an auxiliary to the first juvenile court in America. The uniqueness of his enterprise was his demonstrated belief that the psychiatrist must work closely with the clinical psychologist and the social worker in diagnosing the individual delinquent. Thus was created the first interdisciplinary team. It has since become the prototype of most, if not all, child guidance clinics in the western world.

It was not long thereafter, so the record goes, that the late philosopher John Dewey, in addressing a meeting of the American College of Surgeons, commented on the conventional goal of modern medicine and surgery ("a sound mind in a sound body") by suggesting that this objective be expanded to read: "a sound human being in a sound human environment."

Perhaps the statement which best defines the goals of social medicine is the one formulated in 1950 by the World Health Organization, an auxiliary of the United Nations Organization, which defines health as "a state of complete physical, mental and social well-being; and not merely the absence of disease or infirmity."

In the light of the foregoing, may I now suggest that the broadest conception of alcoholism is to regard it as a socio-psychosomatic illness.

SOCIAL WORK AND MENTAL HEALTH

Before we discuss the question: "How does the social worker deal with the alcoholic?" let me comment briefly on the field of social welfare *per se*. Modern social welfare, broadly defined, comprises all of the arrangements, both public and private, for helping needy persons of every variety and from whatever cause; it is a non-political, non-sectarian enterprise, administered by an ever-increasing body of professionally trained men and women who believe that the social ills of our time will yield to an unselfish, intelligent, cooperative attack.

Social work long ago took its place among the other helping professions because it satisfies an indispensable social need and is based upon a body of specialized knowledge tested by experience. While it is based upon well-established scientific principles, it is, nevertheless, an art, in that it requires the exercise of discretion and judgment. Like the other helping professions, it recognizes its primary obligation to its clientele; hence its members are guided by an accepted code of ethics. To a very great degree it is an interdisciplinary endeavor; yet its uniqueness lies in its own differential methods, case work and group work. Its secondary methods include community organization and administration. Like all other professions, it uses such ancillary processes as research and communication.

Professional social workers are no strangers to the problems of mental disorder and mental health; their education in the behavioral sciences and their training in so-

cial psychiatry—especially in preparation for such specialties as psychiatric social work, orthopsychiatry and corrections—qualifies them to play an increasingly important role in this major field of endeavor. Moreover, they are sensitive to the fact that the ultimate solutions depend more upon the methods of prevention than the techniques of cure.

From their knowledge of the mental hygiene movement, they remember too that three of its founders were dedicated laymen: William Tuke (1732–1822), the Quaker who established the Retreat at York, England; Dorothea Lynde Dix (1802–1887), whose humanitarian zeal gave us the state hospital system of care in this country and abroad; and Clifford Whittingham Beers (1876–1943) whose autobiography, *A Mind That Found Itself* (8), dramatically ushered in the national and later the international movement now known as the World Federation for Mental Health. This does not, to any degree, denigrate the profound contributions of the medical pioneers—Pinel, Rush, Charcot, Freud (and his brilliant disciples), James, Meyer, von Jauregg, the Menningers and others.

THE ART OF FACING REALITY

I want now to deal with some basic ideas in mental hygiene which I frequently discuss in university lectures. The caption, The Art of Facing Reality, helps one, I believe, to see both the positive and the pathological aspects of the matter in proper relation.

It is a truism of social psychiatry that in the relentless process of living, personalities sometimes become warped or distorted. If the pressure of the environment is too intense or the organism is constitutionally (or momentarily) weak, the personality may warp or even disintegrate.

The nature of this process has been aptly phrased by Samuel Butler in the following excerpt from his well-known satirical novel, *The Way of All Flesh:* "All our lives long, every day and every hour, we are engaged in the process of accommodating our changed and unchanged selves to changed and unchanged surroundings; living, in fact, is nothing else than this process of accommodation; when we fail in it we are stupid, when we fail flagrantly we are mad, when we suspend it temporarily we sleep, when we give up the attempt altogether we die."

How do people customarily face such routine realities as the day-to-day problems of illness, disappointment, grief, etc.; the chronic failures in employment, in family life, marital relations, etc.; the gnawing feeling of inferiority; "success" in all its forms, "power and glory" arising from wealth, position, rank, authority; the "triumph and disaster" impostors of Kipling's "If," etc.?

What, then, are the general characteristics of mentally healthy people? In the absence of an authentic definition, I submit that the mentally healthy person is one who customarily faces life's realities at the proper time and in a socially approved way. Such people are emotionally stable, we say, and their peace of mind is a by-product of self-knowledge.

There are, of course, three general patterns of escape from the stresses and strains of daily life. The first may be called "harmless," and includes that endless array of diversional activities such as play, travel, amusement, etc. The second category comprises those activities which can be called "helpful," and includes all re-creative activities, avocational pursuits, hobbies, etc.; to many people, vocations and religious activities also constitute "helpful" energizing escapes from stress.

The third pattern of escape includes all of those "harmful" evasions which lead away from mental health; together, they

make up that omnibus category, "mental illness," in one form or in one degree or another:

- Chronic procrastination and the "paralysis of hesitation."
- Re-defining the social situation by rationalization, self-justification and blaming others or by falsification, misstatement and lying.
- Putting the matter "out of mind" by changing the appearance of reality by means of alcohol, narcotics, tranquilizers, etc.; by repression or dissociation; by escape into psychoneuroses (anxiety attacks, psychosomatic-system reactions, depressive reactions, hysteria, obsessive and compulsive reactions, etc.); by escape into fantasy hallucinations, delusions, disorientation and other psychotic symptoms); by sociopathic and psychopathic "acting out" escapes, arising from hostility and aggression, resulting in violence, crime or delinquency.
- Running away, as in truancy, desertion or wandering, and in suicide, the irrevocable escape.

SOME PRINCIPLES OF MENTAL HYGIENE

Offsetting the foregoing inventory of "harmful evasions,"—a somewhat melancholy list, to be sure—are the following prophylactic principles of mental hygiene. It is a short catalogue of axioms and lays no claim to finality or completeness:

1. Activity is the normal characteristic of personality; physical and mental inactivity are pathological.

2. Mental poise is facilitated by an alternating program of work, rest and play.

3. The differences between personalities are so great as to make it dangerous to prescribe the same treatment for all individuals.

4. Almost all persons have some degree of inferiority feeling; compensations for actual or imagined inferiority are quite normal. The problem is to derive appropriate compensations.

5. Every person should experience success or superiority in some field or situation with sufficient frequency to prevent the development of an inferiority feeling.

6. Many personality problems are overcome when the handicapped person is able, through the assistance of others, to objectify his own difficulty as though it were the problem of another.

7. Man's ego is normally shaped and held within bounds by the attitudes and responses of others, a dynamic process of interaction aptly suggested by the poet Burns in the famous couplet: "Oh wad some power the giftie gie us, To see oursel's as ithers see us!"

8. Energies, instincts, emotions, impulses, etc., cannot be successfully repressed; they may, however, be sublimated, that is, reconditioned to constructive ends. (In a recent report, *Evaluation in Mental Health,* the following statement appears: ". . . personal values, professional judgment and evaluative research studies yield a consensus of evidence that gratification and affectional relationships are superior to deprivation, rejection and severe frustration in the development of a healthy personality" (9).

9. All persons, at one time or another, normally need a confidant, that is, some understanding person who will listen without moralizing. Herein lies the cathartic value of companionship, prayer, the confession, psychiatric treatment, group therapy, membership in "Alcoholics Anonymous," etc.

ALCOHOLICS ANONYMOUS

"A.A." is a socio-psychological invention of great significance, for it demonstrates the

powerful dynamic of the small, intimate group where there is harmony, rapport and empathy. The spontaneous origin and spread of the movement attests the need it meets in the alcoholic whose first victory is his admission that he needs help; and second, his identification with a peer-group in the same predicament.

The "anonymous" aspect of the group is a double guarantee of secrecy and confidentiality, plus immunity to the two social institutions towards which the alcoholic may be hostile: the church, which moralizes, and the law, which punishes.

Another strength of the movement is its ability to remain informal and unstructured, and to resist the American tendency to expand. (See also *Alcoholics Anonymous Comes of Age* (10).

EDUCATION AND RESEARCH

What is greatly needed in our public schools is a comprehensive program of mental health and character education—not alone as a specific preventive of alcoholism but as a general prophylaxis against the pervasive stresses of the atomic age. Moreover, there is no enterprise of any consequence that cannot be enlightened by research. The *Quarterly Journal of Studies on Alcohol* is a symbol of this approach. However, I predict that the social and behavioral aspects of alcoholism will receive vastly more attention in the future than they have in the past.

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The impact of phrenotropic drugs on hospital psychiatry

Phrenotropic drugs represent the latest form of treatment available for the hospitalized mental patient. Unlike other recent modalities of somatic therapy, such as insulin coma and electric shock, the phrenotropic drugs have made a profound impact on the structure and goals of the mental hospitals. The effects have reached even beyond the hospital into the community, influencing the whole conception of mental illness and how it should be treated. This development and its consequences is paralleled only by Pinel's breaking of the chains and Freud's insistence that mental illness can be understood and treated. For the first time, the patient, his relatives and the public at large have witnessed profound changes in mental symptomatology produced by external intervention. Even if cure has not been achieved, the expectation that someday this might be within our grasp has certainly been kindled.

The purpose of the present paper is to examine the effects of the large-scale use of phrenotropic drugs on the patient's view and attitude towards the hospital, on the hospital-patient relationship, on hospital personnel, on the patient's family, on rehabilitation objectives and finally on the hospital climate.

Before these topics are developed, some general remarks on the direct effect of drugs on patients, chiefly the schizophrenic group, are necessary as a background.

EFFECTS OF THE TRANQUILIZING DRUGS ON PSYCHOTIC SYMPTOMATOLOGY

From the outset, it should be stated that the drugs have proven no cure-all. In patients with depression without agitation, results

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have been disappointing. Only a relatively small number of long-term patients have been discharged from the hospital "completely recovered" purely as a result of drug treatment. A larger percentage can now be carried on trial visit status, needing some, however tenuous, tie to the hospital. We find that while schizophrenic patients show improvement, they still exhibit limited initiative and spontaneity, and though they are more friendly and pliable, their basic emotional tone often remains essentially unchanged.[1]

In spite of these limitations, the drugs have produced drastic changes among the patient population of the mental hospital. Without doubt, the drugs have a physiologically quieting effect on the patient; he not only seems calmer and less disturbed by his environment, but objectively reports that he feels more at ease. Most important, the patient receiving a tranquilizer does not lose his responsiveness to the environment, in contrast to the patient receiving a barbiturate, which is in a sense, a chemical straight-jacket. Beyond tension reduction, the tranquilizing drugs may often have other physiological stimulating effects.

Clinically, tranquilizing drugs check motor excitement, agitation, noisiness and assaultive behavior. Control of tension and anxiety in turn reduces the patient's need to engage in attention-getting behaviors such as meddlesomeness, clinging, repetitive mechanisms or pathological fault-finding. Furthermore, inhibitory states such as catatonia and negativistic attitudes are overcome. As a consequence of these effects the patient shows less preoccupation with internal phenomena and pressures. He does not need to channel all available energy into autistic self-observation, which often results in distortions of reality with attendant, bizarre delusions or hallucinations. Instead, his attention is more easily directed towards the environment and he appears better organized. Thus, he shows more interest in self-care, such as cleanliness, food intake, physiological body needs, and becomes more reliable in handling privileges, work assignments and financial matters.

CHANGES IN THE PATIENT'S VIEW AND ATTITUDE TO THE HOSPITAL

Perhaps the most important consequence of the use of the drugs has been the radically different impression which the patient has of the hospital upon admission. To begin with, the pre-hospital use of tranquilizing drugs has meant that fewer patients now arrive at the hospital in states of acute excitement, confusion or panic so characteristic of former admissions. Those already treated with drugs, even though unsuccessfully, are apt to look upon the hospital as a place where their previous therapy will be continued and intensified.

Patients who *are* admitted in acute, excited states regain some equilibrium much faster with this new medication. We less frequently encounter lengthy confusional states which formerly led patients to misinterpret the methods and purposes of a mental hospital, resulting in early attitudes of resentment, hostility and strong disposition to non-cooperation. Furthermore, they no longer are frightened by rumors of drastic treatments, such as electric shock, insulin coma and lobotomy as being the major treatment modalities in the hospital. The prescription and administration of drugs, as well as regular laboratory work-up now parallel the more familiar experience of a general hospital. Thus, they are not as likely to feel mystified when admitted to a

[1] This fact has led some psychoanalytic psychiatrists to voice reservations in the use of tranquilizing drugs, insisting that overcontrol of anxiety interfers with effective psychotherapy.

mental hospital and they more readily accept hospitalization, although originally they might have been against it.

What are the consequences of this development? First of all, many patients are more tolerant of initial restrictions which the hospital might find it necessary to impose. Secondly, they are more willing to cooperate with the hospital in matters of commitment. When patients were not expected to understand the necessity of hospitalization, they looked at it negatively, chiefly as confinement, with the result that involuntary commitment through the courts was practically routine. Understandably, commitment entails possible unpleasant repercussions and stigmatization, affecting such matters as civil rights, driver's license and future job opportunities; it may even endanger the patient's previous position in the family.

Since the advent of phrenotropic drugs we have been able to carry most patients on voluntary commitment. This reflects a favorable view of the hospital by the patient and eases general administrative features such as the granting of privileges and the conduct of activity programs.

In regard to privileges one could say that the most difficult adjustment that a patient has to make to hospitalization is his often protracted loss of freedom of movement. This no doubt is related to the great emphasis that our culture places on the value of freedom and self-reliance. With the use of drugs we have found that patients can be depended upon to handle ground privileges very early in their hospitalization. This not only prevents much resentment and irritation by the patient but also promotes in him a feeling of trust and responsibility.

In the case of activity programs we find that many more patients are willing and able to participate in some form of activity, rehabilitative or simply recreational. In fact, many of our facilities have been severely taxed to meet the demand by the patients to be occupied.

CHANGES IN HOSPITAL-PATIENT RELATIONSHIPS

One of the chief problems of any large psychiatric hospital is to provide care and supervision for many hundreds of patients. Moreover, it is well known that most of these hospitals are operated with a relatively small professional staff. In contrast to private practice, where the emphasis is on the study and treatment of intrapsychic features of the patient's disturbance, the professional staff of the large mental hospital has had to search for other therapeutic resources and techniques beyond individual therapy to reach the great majority of their patients. One result of such efforts was the awareness of the clinical significance of socio-environmental factors in the mental hospital setting.

Viewing the hospital as a subculture (containing socio-cultural factors and functions) has led to remarkable improvement of patient care and treatment. For example, many time-honored hospital stand-bys, such as restraints, seculsion rooms, hydrotherapy, "closed" wards, etc., have been drastically reduced or even abolished. While the professional staff welcomed these developments, there still remained the hope and expressed need that more individualized attention for patients might someday be possible. The phrenotropic drugs have unexpectedly provided us with the opportunity to give individualized treatment to large numbers of patients. Since drugs have to be prescribed, administered and readjusted on a day-to-day basis, it follows that the patient has to be treated as an individual.

This *de facto* recognition of the patient as an individual, always the announced goal of the therapeutic milieu, is illustrated during daily rounds when doctors and

nurses make solicitous inquiries of the patient as to how he "feels," often relying on his own evaluation as a gauge of improvement or side effect of the drug.

This contrasts with the former attitude of hospital personnel towards the patient's account of somatic sensations, most of which were given little actual weight, being solely interpreted as projected expressions of interpersonal conflict into body language. While this insight is still valid for understanding the dynamics of the patient, it has always remained of limited practical value in the hospital setting where there was no way to follow through in psychotherapy. Thus, in effect, the personnel operated in a different frame of reference from the patient, who consequently felt misunderstood, neglected or even hurt. Now, with the experience that at least some of his physical symptoms are given actual consideration, it is easier for the patient to feel understood.

This personalized contact with the patient is also evident in relation to voluntary commitment. Not infrequently during the course of their illness, patients may demand to be discharged before being ready for it. Handling such requests calls for much tact, skill and flexibility by the personnel. It is to be recognized that this places additional strain on the personnel, yet ultimately makes for more genuine interaction which the patient recognizes and appreciates.

In the light of these developments in hospital-patient relationships, it is only natural that we should re-examine in detail the changes in the role of key professional personnel in the hospital.

EFFECT OF DRUG THERAPY ON HOSPITAL PERSONNEL

Hospital personnel have been affected in two ways by the extensive use of phrenotropic drugs. On the one hand, professional groups such as psychiatrists, nursing personnel, social workers and psychologists have felt the need to redefine their role in respect to the patient as well as in relation to each other. On the other hand, there has occurred a shift of emphasis as to the contribution of various hospital departments and services to patient care.

THE PSYCHIATRIST

In discussing the changing role of the psychiatrist we must first note that he has been traditionally in short supply in the mental hospital, and present trends indicate that there are no real changes in the offing. Moreover, most psychiatrists have been largely utilized for "medical-administrative" purposes (annual physicals, night duty, medical emergencies, processing records, classification of patients, insurance and compensation reports, preparation of abstracts, and coordinating functions). In planning his work the psychiatrist was apt to give precedence to medical-administrative urgencies over purely therapeutic, time-consuming contacts with patients. Because of varied commitments the psychiatrist maintained only marginal, often only token, contact with the patient.

He therefore welcomed recent trends which brought about a decentralization of patient care, which gradually came to be looked upon as a joint enterprise of many specialized departments, such as social service, vocational counseling, physical medicine, and rehabilitation with its many "clinics" and varied "therapies." However, since these departments also had only marginal contact with the patient, the concept of the psychiatric team was developed in order to round out a whole picture of the many facets of which a patient's personality, problems and difficulties were reputedly composed.

As noted earlier, large-scale use of phrenotropic drugs have made more direct

demands on the hospital psychiatrist, requiring him to have almost daily contact with the patient, to map out his progress step by step—in relation to drug dosage, to his hospital program, to his plans for the future. Since delegation of these functions is not easy, the psychiatrist is forced to assume a more active, central and therapy-oriented role with the individual patient instead of being purely a ward manager and nominal captain of the team.

It is interesting to point out that this development came just at a time when some hospital psychiatrists began to embrace dynamic concepts and were ready to acknowledge that patients could be helped in other ways besides external intervention and manipulation. These psychiatrists began to look upon themselves more as agents intent on the mobilization of the patient's own inner resources, by keeping involvement and external intervention at a minimum. They tried to modify this ideal role to some extent in order to meet the practical demands of actual hospital practice.[2] Just when a satisfactory balance between a directive and a non-directive role seemed to be achieved, the equilibrium became upset with the advent of phrenotropic drugs and once again the hospital psychiatrist became committed almost exclusively to methods of external intervention.

This has had several consequences. The most important one, from the patient's point of view, concerns the well-known disposition to endow the psychiatrist with magical powers inherent in all medical practice. The patient is only too ready to rely upon magical forces and external intervention in preference to a more prolonged and painful therapeutic process. It becomes incumbent upon the psychiatrist to strike a healthy balance between applicable dynamic concepts and taking proper advantage of the new drugs which, after all, are the prototype of external intervention.

NURSING STAFF

In the case of nursing personnel we find that the function of the psychiatric ward nurse is also changing. Just recently she has been urged to carve out for herself a psychotherapeutic or socio-therapeutic role with respect to patients under her care. We now find that she has to return in some respects to the traditional duties and functions of the nurse. Not only is she busy much of the time administering drugs, but in addition the ward physician has come to rely upon her to watch for possible medical side effects and to help him evaluate results of the therapy.

The more sophisticated, dynamically oriented nurses are reluctant to shift the emphasis of their contribution to patient care, while other nurses have been especially gratified to know that patients now are actively receiving treatment which they themselves can understand. Previously, despite all training efforts, many nurses had remained mystified and unconvinced as to how the psychiatrist was attempting to help the patient. One of the challenges for psychiatric nursing will be to integrate the socio-therapeutic notions with the functions of the traditional nurse.

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[2] One might think, incidentally, that this dual function might have a unifying influence on the previously deeply split schools of the organicist on the one hand and the strictly dynamically oriented psychiatrist on the other. As both schools approve the use of drugs, we note that the former has wholeheartedly welcomed these new treatment opportunities at the expense of dynamic concepts, while the latter has been giving them reluctantly—pointing out that the drugs merely serve to increase psychotherapeutic opportunities. Thus both schools attempt to retain, if not to reinforce, their original orientation.

PSYCHOLOGIST

The psychologist has been a relatively recent addition to the mental hospital organization. His role has been of a varied nature. Originally he was engaged primarily in psychological testing, chiefly for diagnostic purposes. Over the years he has assumed additional functions such as research and psychotherapy, and of late he has made useful contributions as a social scientist. He has been considered a member of the therapeutic team.

As the need for diagnostic refinements diminishes and as individual psychotherapy becomes less practical or economical in the large mental hospital, especially with the recent tendency of rapid patient turnover, a new role has to be assumed by the hospital psychologist. In addition to his contributions as researcher, individual and group therapist and social scientist, he could perhaps best serve the hospital by taking over certain administrative functions in connection with the ward organization, freeing the psychiatrist for more actual therapeutic duties.

SOCIAL WORKER

The social worker has always been the connecting link between the hospital and the patient's family. In order to study the social background of the patient, much of the social worker's efforts were spent on time-consuming home visits designed to appraise the family constellation in its own surroundings. The social worker would also spend many hours interpreting to the family the long-range nature of the patient's illness, the paucity of our treatment armamentarium and the nature and goals of a mental hospital.

With the shortened duration of the patient's illness and the more ready acceptance of the mental hospital, this particular function of the social worker has lessened. Rather, with the arrival of drug therapy, there arose an urgent need for prompt and continued contact with the family (and often with the employer). To meet this demand our hospital has added a resident social worker to the admission ward. This was done not merely as a convenience permitting the social worker more effective use of her time than might be achieved by home visits, however desirable these might be. It was found that special benefits resulted from ready communication between the social worker, the family, the ward physician and the patient. Thus, the social worker can be utilized more effectively to deal with basic attitudes arising within the matrix of the family and affecting the patient.

In this way the patient's return home can be materially speeded up and the family can be helped to accept the patient's striving for a greater measure of independence. Furthermore, the social worker is valuable in arranging meaningful psychiatric follow-up upon the patient's release.

DRUG THERAPY AND THE PATIENT'S FAMILY

The effect of drug therapy on the patient's family has been very rewarding. Often families have already heard of this new treatment from the newspapers, and they are apt to insist that the patient be tried on medication.

We have observed definite changes in the family's relationship to the hospital purely as a result of drug therapy. In the past, families often tended to shy away from psychiatrists and social workers because of the implication—part of our present culture—that the family is in some way to blame for the patient's sickness. This engendered in the members of the family closest to the patient certain feelings of

guilt and shame often motivating them to justify their position with the hospital. Frequently they have felt under pressure by the hospital staff.

With less stress on interpersonal causation of mental illness and greater emphasis on the varieties of treatments available, the hospital personnel meets the family in a more relaxed fashion; the family in turn appreciates being continually informed and in the picture in regard to the patient's treatment and progress. As a result, they are often desirous to be helpful to the hospital. They are prepared to continue contact with the patient either by regular hospital visits or by allowing frequent home visits. They also are disposed to make allowance for the patient's unpredictable behavior. This latter situation is easier since the drugs do much to minimize the type of behavior which families might find most objectionable.

The drugs have helped the family from the start to be more hopeful regarding the patient's prognosis. Rather than visualizing the illness as the start of a prolonged and often hopeless disease process, they now can look upon the patient's disturbance as nothing more than an episodic occurrence.

DRUG THERAPY AND REHABILITATION CONCEPTS

The term *rehabilitation* in its widest meaning connotes restoration of a condition to a former state of functioning. In this sense, all efforts in behalf of patients, both psychiatric and medical, can conceivably fall into the province of rehabilitation.

In its more specific sense the term *rehabilitation* is applied to methods and goals of various modalities of activity and "treatment" offered by specialized departments in a mental hospital such as occupational therapy, industrial therapy, manual arts therapy, educational therapy, physiotherapy, etc.

Originally, the model for psychiatric rehabilitation was taken from experience gained in working with the physically handicapped, in whom long periods of retraining are common (the origin of this concept is even shown in the name of the Department of Physical Medicine and Rehabilitation).

Large-scale use of tranquilizing drugs has made it clear that mental illness does not necessarily follow the course frequently observed in the field of physical medicine. Psychotic patterns are as often resolved by "crisis" as by "lysis"; that is, sickness and improvement may occur by sudden rearrangements of the mental "set" rather than by slow symptom-by-symptom progression.

Yet the notion of a slow and gradual convalescence has profoundly influenced our thinking in the field of psychiatric rehabilitation. Thus, in line with this gradualistic view, arose certain procedures and practices, the most important of which perhaps is the rehabilitation "team."

The team is composed of representatives of various services in the hospital and usually includes the ward physician, the psychologist, vocational counselor, members of the physical medicine and rehabilitation service, a nurse and a social worker. These services are considered to represent separate disciplines. A major function of the team is to avail the patient of its varied skills in an integrated manner.

It is to be recognized, however, that even though each team member considers himself a representative of a separate discipline with specialized professional methods, techniques and insights, in reality these services are only subdivisions of one discipline—namely, the medical-psychiatric—and thus cannot be compared to interdisciplinary teams applicable in other scientific fields.

The team approach does certainly facili-

tate communication among the services concerned with patient care. However, it can work only if the contribution of each member is carefully weighed as to its significance. While in theory it is understood that the services are not of equal value, in practice there is frequent tendency to give everyone equal voice in evaluating the patient and planning for him. The implication is that a democratic resolution is also a therapeutic one.

The formalized psychiatric team is chiefly concerned with long-range planning for the patient. Patient movement being slow, there is no need to arrive at rapid decisions since at each stage the team can avail itself of prolonged periods of observation. As a consequence we may find a tendency to stress the specific contribution of team members, often leading to professional status problems with the possibility of losing sight of the patient's own adaptive resources. Furthermore, caution, sharing of medical responsibility and team communication may be overemphasized, while the patient often has a chance to solidify his symptoms.

In line with slow patient progress, cumbersome and detailed administrative routines were developed in respect to hospital work assignments, vocational planning, ground privileges, passes, trial visits and discharges. Not long ago most hospitals held staff meetings before many of these decisions could be made. The delay often actually retarded the patient's progress. It is even clearer now, with the use of new drugs, that this is the case. Briefly, it has been our experience that the team's chief rehabilitation challenge is to quickly adjust to the patient's needs without lagging behind more than necessary. While in the past the hospital personnel waited for the patient to improve, it appears that now the patient must wait for the personnel to adapt to his needs.

It must be stated that even before the use of tranquilizing drugs we witnessed a gradual shift of emphasis in the facilities used in our rehabilitation program. For instance, physiotherapy was reduced to a minimum. Wet sheet packs, tubs and other forms of hydrotherapy are today only of historical interest.

The usefulness of educational therapy and industrial retraining as such have been questioned for some time, since in practice few patients have availed themselves of these long-range retraining facilities. Educational therapists themselves have recognized this and they now talk more about "therapy through education" than "education through therapy." One reason for this impasse is that very sick patients do not have the interest, attention span and long-range planning ability to pursue such complex programs. The improved patient, on the other hand, who could use such facilities, usually prefers to receive training outside the hospital—a desire which should, of course, in the main be encouraged.

Phrenotropic drugs again have further accelerated this trend. On the one hand, since more patients are available and ready for certain types of rehabilitation activities, the need has arisen to keep a great many patients busy in some manner so that they would not be left on the wards to slumber. This has forced the hospital to find suitable, albeit less specific, activities for the many, rather than concentrate on meaningful activities for the few.

One consequence is the revitalization of industrial therapy programs, which have always been popular with improved patients. Another development in our own hospital was with the creation of an entirely new project called the Community Work Shop; patients are taken to various places of employment in the community and receive regular wages for their efforts. This,

as well as a "member employee" program, represent valuable transitional phases of vocational rehabilitation and as such should be further explored.

On the other hand, we have found that as patients show even moderate improvement they become better organized and more reality-oriented, and they express the desire to find activities outside the hospital. Thus, many of our patients have been accustomed to spending prolonged weekends at home. In a sense we have become a mid-week hospital. Incidentally, these home visits may be utilized by the patient to find employment and often lead to trial visit or early discharge.

All these developments have compelled the psychiatrist to speed up and simplify administrative procedures. Often he is forced to make decisions without being able to involve the team. In fact, the patient is often ready to (or should) go home before the team can meet to formulate long-range plans.

THE HOSPITAL CLIMATE TODAY

In studying our newly admitted patients we have found that they usually come to the hospital because of the sudden appearance of a psychiatric crisis or emergency. The crisis may arise from various sources, some of them within the patient, others within the environment. After resolution of the crisis, patients are usually returned to their previous environment even though treatment for their mental illness may still be necessary.

The chief contribution of the drugs has been to speed up the resolution of the crisis. One result of this has been the gradual disappearance of rigid differentiation of hospital wards between "acute," chronic, convalescent, etc., and patients need not necessarily reside on different wards during various phases of their illness. Now, on any given ward one might find patients in various stages of regression or improvement. The so-called "closed wards" have practically disappeared, and privileges, passes and discharges are being granted from any ward in the hospital.

The trend toward using the hospital chiefly as an emergency station during a psychiatric crisis can be further demonstrated by the tremendous increase in patient turnover since the use of the drugs. Bedford, for instance, a 1,750-bed hospital, had a patient turnover of 470 in 1952 compared to 992 in 1957. Patients are now easily admitted to the hospital and just as readily discharged. This creates a constantly fluctuating population which, as a whole, has less investment in the hospital as a community than when the population was more static in nature.

This situation has profoundly influenced the hospital climate. It was not long ago that we thought of the hospital as a "community." This apparently useful concept, especially in the care of long-term patients, viewed the hospital as a miniature replica of the outside community. It was felt that such a model would aid the patient in becoming re-educated to assume eventual real community responsibilities. If on the other hand he failed to achieve extra-hospital status, he was in a sense provided with a ready-made substitute community which he could accept and which would be accepting of him. Only too frequently the patient from the beginning preferred to make the second choice, creating an added difficulty in rehabilitation efforts.

Thus, it is felt that one of the major contributions of the drugs has been to reach and influence the patient before he could make the second choice of accepting the hospital as a substitute community and thereby destroy the roots, however tenuous, which he has on the outside.

It is obvious that with the patient becoming less immersed in the hospital, the culture, function and need for the hospital to be a substitute community has been profoundly altered.

OUTLOOK

The extensive use of phrenotropic drugs has brought psychiatric hospital concepts and practices into new focus.

The hospital has become, in the main, a place where a patient can receive short-term emergency treatment for a psychiatric crisis. The drugs have helped to speed the resolution of the crisis and the patient is ready to profit sooner from out-patient therapy for the underlying mental illness.

This effectively relates the mental hospital to other community resources. Thus, as the hospital loses its former isolation the patient continues contact with the family and the community. In fact, the family, as well as the employer, have come to look upon a mental disturbance for which hospitalization becomes necessary as nothing more than an episodic occurrence during a person's life.

Within the hospital we note the emergence of new and clearer definitions of the roles of key personnel in the total treatment program, with a return to primary responsibility for psychiatric care to the physician and nurse. Furthermore, a clearer picture of what the hospital can and should attempt in the way of patient rehabilitation has developed.

From the patient's point of view, the mental hospital has become more acceptable and less frightening. Above all, there has arisen some opportunity to provide a measure of actual individualized care to patients in a large mental hospital.

Finally, it has become apparent that, despite present limitations of drug therapy, as far as eventual cure of mental illness is concerned the drugs significantly reduce, or may even prevent, the traditional chronicity of psychotic illness.

Present needs arising out of intensive use of drug therapy are:

- For the hospital to modify its organization and structure so as to avail itself fully of the opportunity to exploit the patient's accelerated recuperative momentum induced by phrenotropic drugs.

- For the hospital and the community to cooperate in devising adequate and meaningful follow-up facilities, continuing psychiatric and rehabilitative services for the patients in the community.

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Evaluation of a mental health week program

Part 2

SELECTED GROUP FOLLOW-UP: CLERGYMEN

Throughout the country, state mental hospitals have each year become increasingly involved in conducting Mental Health Week programs designed to enhance public understanding of this nation's #1 health problem.

Realizing the tremendous expenditure of the hospital staff's time and energy—literally more than 1,000 man-hours for professional personnel alone—being devoted to this annual project, the administration decided to take stock. Therefore, an exploratory evaluation was completed in which the value, structuring and effectiveness were assessed for such a Mental Health Week program [1] as it was conducted at a representative (1,500-bed) midwestern state mental hospital. That investigation evaluated the effects of the program upon those participating *at the time of the program.* As important as such "at-the-time" attitude changes are in assessing effectiveness, it is equally essential to evaluate the longer term effects of participation and the resultant potential of the participants for influencing others through their subsequent activities.

The present study is the first of two separate investigations which make this type of follow-up evaluation of post-participation effects with selected groups chosen as having a particularly significant potential for secondary or "radiated" influence upon others in their community. Because of their unique position in the community,

The co-authors of this paper are all on the staff of Larned State Hospital in Kansas. Their study—the first part was published in the April 1958 number of MENTAL HYGIENE—was one project of an interrelated group research program conducted by the hospital's department of clinical psychology.

[1] Sommer, Dirks, Gardiner, Hinkle, Khanna, McDonald and Pratt, "Evaluation of a Mental Health Week Program," *Mental Hygiene,* 42(April 1958), 195–210.

clergymen were chosen for this study. County officials and social workers were selected for the other follow-up investigation as they likewise play unique roles linking hospital and community. Such assessments should add a further dimension to the evaluation of the effectiveness of a Mental Health Week program.

PROCEDURE

A multi-type 36-item questionnaire was constructed and sent, four months following the Mental Health Week program, to the 71 clergymen who had specifically registered as such (that is, part-time and/or lay "preachers," etc., were not included) out of the 134 persons who registered their attendance during the Mental Health Week Clergymen's Day program at the hospital. Items of the questionnaire were presented in various forms to facilitate response and expression (for example, "yes-no-don't know," "fill-in," "open-end," "report frequency and/or type," "give examples," etc.). A tracer was sent to those few who did not respond immediately. The questionnaire was completed and returned by 58 clergymen (82%).

Specifically, this follow-up was designed to investigate such questions as these:

- As assessed after a considerable period, had the program been effective in increasing interest in mental health, forming constructive attitudes toward emotional illness, heightening awareness and concern regarding problems in these areas?

- In what ways, if any, had participants transmitted new knowledge and awareness to colleagues, parishioners and community, subsequent to the program?

- Subsequent to and ostensibly as a result of participation, in what ways, if any, had these clergymen instigated or participated in overt activities relevant to mental health (for example, counseling, referrals, incorporating material in discussions or sermons, etc.)?

- What, if any, activities of this type do they contemplate for the future?

Responses from the completed questionnaires were analyzed and evaluated to find answers to these and similar questions. In brief, what were the continuing effects of their having participated in the Mental Health Week program as perceived and expressed by the clergymen themselves? Did these results, as reported, involve communication and activities which would indicate the spread or "radiation" of such effects to others in their community?

ATTITUDE CHANGE

It is evident from the original evaluation[1] that a large proportion of those participating in the Mental Health Week program, as reported by them *on the day they attended,* felt at that time that the experience had increased their interest and constructively changed their attitude toward the problems of mental illness. The salient question was, would they still perceive themselves as having undergone or undergoing this positive change in attitude long after the program was passed? Educators are only too painfully aware of the short-lived effects of most well-intentioned attempts to influence public opinion on matters of personal and social concern, particularly in those areas where myth, stereotype and prejudice prevail.

In Table 1 we see to what extent the clergymen, reporting four months subsequent to Mental Health Week participation, still perceived and presented themselves as having had their attitude toward the problems of mental illness constructively changed.

TABLE 1

Attitude change

RESPONSE		YES	NO	DON'T KNOW OR OMITTED
Reported change of attitude		45	8	5
Specified change of attitude* toward:				
Treatment of mental illness	21			
Problems of mental illness	28			
The state mental hospital	3			

* Some clergymen wrote in more than one example.

Forty-five of the respondents (78%) directly reported such changes. Another 10% stated that while they could not ascribe their favorable attitudes to the Mental Health Week program *per se* they were aware of the problems and expressed sympathetic interest toward patient treatment, the institution, problems of mental health, etc. Examples written in by the clergymen indicate that the two major areas of change involved attitudes and beliefs concerning mental illness (54%) on the one hand and treatment procedures and prognoses (40%) on the other. Only three volunteered examples specifically mentioning change in attitude toward the hospital as such. It could be assumed that in a sense changes in attitude toward the hospital *per se* were absorbed into the areas of mental illness and treatment.

INFORMATION AND UNDERSTANDING GAINED

Here again, it had been found in the original Mental Health Week study [1] that at the time of attendance participation was perceived as a learning experience.

It can be seen from Table 2 that 51 of the responding clergymen (88%) still perceive themselves, after this considerable passage of time, as having increased their understanding and knowledge of mental health and related activities. Examples given by the respondents reflect the variety and specify the areas of increased knowledge. Nineteen (33%) now credited Mental Health Week participation with a significant increase in their sensitivity to personality problems and awareness of the emotional difficulties or disorders of their parishioners. Thirteen (22%) indicated furthermore that

TABLE 2

Information and understanding gained

RESPONSE		YES	NO	DON'T KNOW OR OMITTED
Obtained new knowledge or understanding		51	1	6
Specified area of increase:				
Awareness of personality disorders	19			
Ability to "deal" with emotional problems	13			
Understanding referral procedures	24			
Knowledge of treatment	21			

they now felt better equipped to "evaluate" or "handle" (what to do and what not to do) emotional disorders and/or mental illness. Twenty-four (41%) specifically listed increased know-how concerning actual referral procedures or facilities which could be of considerable practical use when situations arose in which parishioners and their relatives would require such knowledge. This might realistically include very real emergencies (psychotic homicidal outbreaks, suicide attempts, etc.). Finally, 21 ministers (36%) gave examples illustrating their increased understanding of the kinds of psychiatric procedures and/or facilities used in the treatment of mental illness.

ACTIVITIES INITIATED

In adding dimensions to the original "at-the-time-of-the-program" Mental Health Week evaluation,[1] findings of the follow-up presented up to this point have in essence been restricted to the fact that clergymen after four months still perceive themselves as having changed attitudes and increased knowledge regarding mental illness. However, the cogent question remains unanswered—what have they *done,* as a result of their Mental Health Week experience, that has increased their own potential or activity with regard to mental health, particularly in influencing, involving or activating others? In short, what have they done that would "radiate" the effects of their experience to others in their profession and community? The import here is indicated not only by their educative role in the community but also by the conservative estimate made by the hospital chaplain[1] that the number of parishioners directly represented by 100 of these clergymen is approximately 25,000.

Responses to this key question are presented in Tables 3a, 3b and 3c. They reveal that the clergymen, ostensibly as a result of Mental Health Week participation, had initiated or participated in a very wide range of such potentially "radiating" activities, from simple "communication" (mentioning attendance) to the organization of mental health study groups. For instance, from Table 3a it may be seen that all but two of the clergymen reported that they had mentioned their attendance to others. Fifty-two (90%) indicated they felt this experience to be helpful by recommending to others that they attend future Mental Health Week programs sponsored by the hospital. Forty-two (72%) indicated that they had made it a point to discuss their experiences in the program with others—as one put it, "to pass on the information gained to other ministers and Christian workers who did not attend the session."

Table 3b relates to communication, proposals and activities reported by the clergymen which directly involve other members of the ministry. Thirty-two (55%) stated that since attending the program they had proposed specific mental health activities to

TABLE 3A

Activities initiated: referring to Mental Health Week program

RESPONSE	YES	NO	DON'T KNOW OR OMITTED
Mentioned their attendance	56	2	0
Recommended future attendance	52	5	1
Discussed Mental Health Week experiences with others	42	2	14

TABLE 3B

Activities initiated: involving other clergymen

RESPONSE		YES	NO	DON'T KNOW OR OMITTED
Proposed mental health activities		32	6	20
Discussed Mental Health Week experience:				
At Ministerial Alliance		27	23	4
With same-faith clergy	16			
With other-faith clergy	21			

other clergymen. In connection with their participation in Ministerial Alliance conferences the following involvement of Mental Health Week experiences was reported. Half of the clergymen had discussed their Mental Health Week experience at these meetings. Such discussions included informal reference to the program and to their attendance, formal announcements of their participation in the program, detailed discussion of these experiences, urging others to attend future Mental Health Week programs sponsored by the state mental hospital, and presentation of definite plans for Mental Health Week activity at the alliance meetings. Sixteen ministers specified that discussion of their experience at the alliance meeting was with clergymen of their own church; 21 (36%) talked with members of religious denominations other than their own, indicating that communication or "radiation" was not restricted to members of the same faith, but was interdenominational. Such communications among clergymen regarding Mental Health Week experiences were reported as having involved both supervisors and supervisees.

The potential of secondary or "radiated" effects generated through the clergymen's participation in such a Mental Health Week program is perhaps most directly reflected by reports and examples of their overt application of knowledge gained through that experience. It can be seen

TABLE 3C

Activities initiated: applications of knowledge gained

RESPONSE		YES	NO	DON'T KNOW OR OMITTED
Applied knowledge gained		54	4	0
Specified application:				
Visits with parishioners	38			
Talking to other individuals	29			
At informal gatherings	18			
Speaking to groups (sermons, etc.)	43			
In teaching (general)	14			
In study groups	14			
Personal counseling	30			
Referrals for psychiatric help	6			

from Table 3c that 54 of the responding clergymen (93%) reported that they had applied knowledge gained through the program, and it is evident that such application and activities exploit the clergymen's role, both professionally as a minister and as a civic member of the community. Thirty-eight (65%) had applied this experience in visits to or with their parishioners; while this was generally with adults, there were also instances involving church youth. On the other hand, half of the ministers specified they had found use for the information gained in talking with other individuals outside of their professional contacts and outside their congregation. Here again, as previously in relation to other-faith *vs.* same-faith communication between clergymen, we see that the "radiated" effects are also interdenominational.

More than one-fourth of the clergymen indicated that they had taken the opportunity of introducing or applying aspects of their Mental Health Week experience in connection with informal gatherings. Three-fourths reported the use of such material in speaking to various types of groups. More than half of these had used the material in sermons. This varied from simply mentioning the topic to developing complete sermons around the mental health theme. An example of extensive use was the organization of a series of sermons on the general topic, "Our Attitudes and Our Health." Seventeen ministers reported incorporation of their newly-gained knowledge into talks to church groups such as women's organizations, guilds, circles and church youth groups, while others utilized the experience in talking to adult groups—for example, civic clubs—outside their church. Some also used it in giving talks to groups composed of ministers (outside the Ministerial Alliance).

Application of the experience directly through teaching was reported by 14 clergymen (24%). Examples given included parochial school classes, regular Sunday School classes, and adult Bible study classes. Some indicated the content—for example, contrasting present-day attitudes toward mental illness and the care of the mentally ill with that depicted in the Bible.

Another 14 stated that they had spread information on mental health specifically through study groups. These included a professional ministerial study group, youth and adult study groups both within and outside the church; the latter included a community organization study group and a study group of professionals interested in a sectarian mental hospital.

Most, if not all, clergymen participate in one form or another (individual, family or group) in personal counseling with parishioners or others who consider the minister to be a mature and responsible person in the community. Thirty responding clergymen (52%) stated that they had used information gained through their Mental Health Week experience in such personal counseling. While this was primarily with adults, application in counseling youth was also reported. That those who had participated in the program at the hospital now found themselves better prepared to understand and deal with some of the more acute problems which arise in connection with mental illness was reflected by the fact that one out of nine clergymen reported having had occasion to use, subsequent to Mental Health Week, information in referring parishioners for psychiatric evaluation, out-patient treatment or hospitalization.

It is of interest to know how soon after their Mental Health Week participation the clergymen first took occasion to utilize the experience gained in applying it through such activities as those discussed

TABLE 4

Time after Mental Health Week within which experience was first utilized

1ST MONTH	2ND MONTH	3RD–4TH MONTH	FUTURE	DON'T KNOW OR OMITTED
29	9	4	6	10

above. Table 4 presents the time after Mental Health Week within which they reported having first put such experience to use. Some of the activities were apparently initiated almost immediately after attendance at the program, and the majority were begun during the first month; only a few were started after several months had passed.

Altogether, nearly three-fourths of the group found means of first utilizing their experience within the 4-month period subsequent to the program, prior to the date of reporting. Exactly half of all responding clergymen had made use of the experience within a month after Mental Health Week. Nine (16%) stated that they first utilized their experience during the second month, 4 within the third and fourth months, while 6 who had not yet initiated activities as a result of the experience reported that they planned to do so in the future.

PLANS FOR FUTURE APPLICATION

In evaluating potential for "radiated" effects of Mental Health Week participation, the clergymen's plans for future endeavors in this area must be considered in addition to activities already initiated or accomplished. Such proposals may relate to new activities to be undertaken as well as to plans to continue or extend current application or utilization of material gained through the Mental Health Week program. In Table 5 it can be seen that 55 of the clergymen (95%) outlined definite plans for future mental health-oriented activities. Expressed plans were varied and overlapped, but for convenience may be presented in five groups.

More than three-fourths of the responding clergymen indicated definite plans to attend the next Mental Health Week program sponsored by the state hospital. Each of the three who stated that they did not plan to do so had moved out of the state. The remainder indicated that they had not yet decided or that there was a possibility that they might be transferred to churches outside the area served by the hospital.

Seven clergymen wrote that they planned to participate in other types of mental health programs—for example, "I also intend to encourage such things as the Health Workshop which has been a county-wide program in my county" and "to bring along all newly-placed ministers in my area." Plans to actively seek further information about mental illness or mental hygiene were presented by eight others. Some of these reported plans to "take advantage of all opportunity to inform myself better," "to work closely with the state hospital chaplain in order to advance understanding of mental health problems," and "to do more personal study in the field of emotional and mental health and participate in the Mental Health Week program again next year."

Seventeen clergymen stated they intended to convey to others the information they had gained through attending the Mental Health Week program. Of these, more than half stated they intended to communicate the information to their parishioners and

TABLE 5

Plans for future application

RESPONSE		YES	NO	DON'T KNOW OR OMITTED
Reported having made plans for future		55	1	2
Specified plans:				
Participate in next state hospital Mental Health Week program	45			
Participate in other mental health programs	7			
Seek additional mental health information	8			
Convey mental health information to others	17			
Use Mental Health Week experience in counseling	14			

about a third planned to discuss it with other clergymen. One minister who indicated that his position with his church restricted non-sectarian activities nevertheless stated his intent to urge other ministers of his district to attend future Mental Health Week programs.

About a fourth of the clergymen wrote in specific plans to utilize their Mental Health Week experience in pastoral counseling. It will be recalled that more than half of the clergymen had reported having already made this application.

DISCUSSION

The findings of this follow-up study should be considered in relation to the following rather global factors: Mental illness and its treatment constitute the single most important health problem facing the country. Perhaps more than for any other illness, effective treatment must involve and take into account patient, family and community attitudes. And these attitudes toward mental illness, treatment and major treatment facilities (that is, state mental hospitals) are laden with pessimism, negativistic stereotypes, myths and prejudices.

Over the last ten years increasing numbers of institutions, including state mental hospitals throughout the country have been conducting annual Mental Health Week programs designed to enhance public knowledge in this area. In view of the overwhelming need for these educative activities but also considering the "exorbitant" effort required on the part of the professional staff to conduct these programs,[1] assessment of effectiveness is a matter of considerable significance both in the number of persons reached through direct attendance and in communicating or "radiating" the effects of their participation to others. There were close to 3,000 visitors at the Mental Health Week program evaluated in the original and follow-up studies. It is estimated that a total of some 15,000 persons have attended the several previous Mental Health Week programs sponsored by this state hospital. Projection of these figures for the next 10 years would mean an additional number that would make an over-all total close to 50,000. Certainly the pebble-in-the-brook model could be applied here to the "radiated" effects as reported in the findings of the present follow-up study. In the clergymen group *per se* it is relevant in considering the findings that each 100 clergymen participating in such a program represents approximately 25,000 parishioners.

To return, then, to some of the implications of the immediate findings. It was found at the time of the original study that on the actual day of attendance the clergymen as a group (95%) reported that participation had increased their interest in problems relating to mental illness, and that while visiting the hospital they were pleasantly surprised, sympathetic and wanted to do something constructive. Thus, the original study indicated that attitudes were changed in a positive direction, interest increased and motivation to do something generated. However much this was to the good, only a follow-up study could reveal whether these attitudes were sustained, the interest continued and the elicited motivation in fact put into effect through overt activities.

Likewise, only by conducting a follow-up investigation could one get at the "radiation" effects or potential of subsequently initiated activities, as these represented communication with others and the involvement of others in mental health-oriented endeavors.

It was seen that 78% of these clergymen specifically reported changes in attitude attributed by them to the experience of participation in the Mental Health Week program. It could be reasonably assumed that such attitude changes served as prerequisites to and provided the springboard for plans and activities subsequently initiated. Likewise, these attitude changes *per se* dovetail with "information and understanding gained" (reported by 88%) in contributing toward the resultant appropriateness and effectiveness of the overt activities initiated. Motivation and action if resulting from uninformed or misguided enthusiasm could have meant less than desirable "radiated" effects, to say the least.

The literature is replete with studies exposing the prejudicial defeatism characterizing attitudes toward mental illness currently prevalent in our culture. Independent research projects[2] conducted at this hospital—Larned State—will delineate and assess the extent of this negativism particularly as directed toward the state mental hospital, which constitutes the major and usually the sole available treatment facility. Clergymen, however, are in a unique position in the community not only to effect public attitude changes but to relate to parishioners constructively through counseling, giving realistic information, and assisting in the making of appropriate referrals. How close they are to such problems was revealed in the original study—without exception every clergyman reported that he had been in personal contact with someone suffering from mental illness. His role-relation at such times with both the patient and family can obviously be crucial. Patient and family characteristically perceive hospitalization in a mental hospital as catastrophic: the snakepit, the end-of-the-road stereotype.

Equally crucial, if not more so, considering popular attitudes towards those who have been "crazy" or in an "insane asylum," is the acceptance received by such patients from family and community upon their discharge. The discharge rate nationally, and particularly in Kansas, has improved dramatically but its ubiquitous shadow, the shocking readmission rate, remains relatively unpublicized. The clergymen's sensitivity to the educative needs of the public concerning mental illness, its treatment and the mental hospital, was unexpectedly (as not directly solicited) revealed in the origi-

[2] S. Pratt, D. Giannitrapani, P. Khanna, "Attitudes of the Town-Community Toward the Psychiatric Hospital-Community." Part 1 was presented at the 1958 convention of the American Psychological Association; parts 2, 3 and 4 are in preparation.

nal study. Under "suggestions for improving the hospital," clergymen singled out hospital publicity and educational programs for mental health as the most urgent needs —whereas other groups stressed such items as plant improvements and increase in staff and patient recreational activities as the most urgent needs. Actually, their stress on this point was sufficient to intelligently restructure the intent of the question posed. Was it, we asked ourselves, naively restrictive?

The crux of the follow-up is to be found in relation to activities initiated (how many clergymen have done what sorts of things) and the secondary effects set in motion by these activities.

Most simply and specifically put, we now know that communication regarding the Mental Health Week experience does not cease as of 5:00 the day of attendance at the program. Most of the clergymen proceed to actively discuss these experiences, with clergymen of the same and other faiths as well as with parishioners and non-parishioners.

These discussions in turn extend into activities which involve changing the attitudes of others toward mental illness; disseminating factual information gained, through sermons, visits, study groups, teaching; proposing and organizing mental health oriented activities and programs; and counseling persons suffering from mental illness as well as giving support and guidance to their families at such times of need.

The original study demonstrated that striking changes in perception of a mental hospital can occur as a result of participation in even a 1-day program: virtually without exception visitors who had expected to see patients as "peculiar-acting" persons and the hospital "like a prison" reported reversals of these expectancies. Since the results demonstrate that clergymen subsequently act to sustain and extend these attitude changes, they are in a unique position to serve as a continuing link between the town and the mental hospital. Nationally, the recent rapid growth of interest at theological seminaries and universities in clinical training and pastoral counseling [3] indicates an extension of concern for spiritual problems to psychological problems and emotional health. The present study underlines the potential of clergymen for complementing and supplementing the hospital's treatment program. Their contribution in the community certainly can immediately affect both inpatient and outpatient services of the hospital. Joint conferences should be arranged periodically between hospital personnel, family physicians and clergymen of each community served by the hospital.

The original study and the follow-up revealed that clergymen as a group are eager to gain more information about mental health and highly motivated to disseminate this knowledge in their community. Further ways in which this involvement can be channeled constructively need to be explored. It was found that most of the clergymen who participated in the Mental Health Week program have since recommended future attendance to others and also plan to attend the following years' program themselves. This re-participation suggests that future programs must provide for variation and for parallel advanced activities such as discussions and panels for "repeaters." However, the central suggestion stemming from this follow-up, in terms

[3] "Clinical Pastoral Training," Council for Clinical Training, 2 E. 103 St., New York 29. Presents training standards and lists 45 accredited training centers in mental and general hospitals, penal and correctional institutions, and specialized hospitals.

of future planning, points to a specific need —namely, that the clergyman's potential mental health role in communication, changing attitudes, initiating activities, influencing and involving others should be consciously considered the primary objective in structuring the clergymen's Mental Health Week participation. This would place a completely new emphasis upon their participation, "radiation" potential, and community-with-hospital role.

In relation to serving as a link between hospital and community, follow-up findings suggest the feasibility of furthering the minister's function as an agent having entree to community circles, a person who can move between two relatively closed social systems. In this role the clergyman can make not just Clergymen's Day of Mental Health Week but every day a time for furthering the mental health movement, for extending the hospital's mental health program throughout the year. As just one example, a hospital-produced movie depicting a patient's progress from admission through treatment to discharge could be presented, not just as part of the annual Mental Health Week program, but with accompanying discussion to church and community groups throughout the year. Analogous extensions of the hospital's Mental Health Week programing (for example, inter-group meetings), materials (for example, an original hospital poster series) and events (for example, panel discussions) could be sponsored by clergymen in their communities as continuing projects. The hospital in turn could arrange additional programs involving clergymen. This could include a periodic series of training seminars, a regular course and practicum in pastoral counseling, work with patients on a planned basis, cooperation and development of the volunteer program, etc.

SUMMARY

Both local and national need, as well as the "exorbitant" cost in staff time and energy involved, argue the necessity of evaluating the effectiveness of Mental Health Week programs sponsored annually by state mental Hospitals. This is one of two follow-up studies designed to add a post-participation dimension to the original "at-the-time-of-participation" assessment. In short, to try to get at the longer term effects of participation upon those who attended and the resultant potential of these participants for influencing others through their subsequent activities.

Clergymen were selected for this study because of their unique position and potential for constructively influencing others and their role linking town and psychiatric hospital communities.

A multi-type, 36-item questionnaire was constructed and sent four months after attendance to the 71 registered clergymen who had participated in Clergymen's Day of the 4-day Mental Health Week program sponsored by a large (1,500 bed) midwestern state mental hospital.

Their responses—82% of the clergymen completed the questionnaire—were tabulated and the findings discussed in terms of Mental Health Week program evaluation and implications regarding the potential role of clergymen in community-patient-hospital relationships. Some of the more significant results follow:

1. Four months subsequent to attendance, 78% of the clergymen specifically reported constructive changes in attitude regarding mental illness and its treatment, attributed by them to their having participated in the Mental Health Week program.

2. After this considerable passage of time, 88% still perceived or presented themselves

as having increased their understanding and knowledge of mental health and related activities: awareness of personality disorders, appropriate ways of handling emotional problems, referral procedures, hospital treatment facilities, etc.

Essentially, these findings indicate that interest, understanding and knowledge gained were sustained. The crux of the follow-up, however, is in the pudding—what they report having done.

3. Most of the clergymen discussed their Mental Health Week experiences with clergymen of the same or another faith, and with parishioners and others in their communities, and then proceeded (93%) to initiate specific mental health oriented activities. Such reported activities involved changing the attitudes of others toward mental illness; disseminating factual information gained by communicating it through sermons, visits, study groups, and teaching; counseling with parishioners and with patients and their families; assisting with referrals; proposing and organizing programs for mental health.

4. The fact that 95% of the clergymen outlined definite plans for future application of knowledge gained emphasizes the continuing nature of their motivation. Their plans extended the scope of activities already initiated.

The implications of the findings were discussed in relation to the "radiation" potential of participating clergymen for constructively influencing others regarding mental health, while stressing the need to structure future Mental Health Week programs in a way that would effect optimal exploitation of both this potential and of the clergymen's role linking hospital, patient and community.

ACKNOWLEDGEMENT

The authors wish to express their appreciation to the clergymen who participated in this research.

Book Reviews

DIRECTORY FOR EXCEPTIONAL CHILDREN; EDUCATIONAL AND TRAINING FACILITIES

Boston, Porter Sargent, 1958. 3rd ed. 320 pp.

Over three and one-half million children in our country require special kinds of education. Locating the right facility for any one of these is to say the least, quite a chore. This third edition of the directory describes schools, homes, clinics, hospitals and services for the socially maladjusted, mentally retarded, emotionally and physically handicapped and many more.

It is advisable to keep in mind that schools at great distances are available for care and treatment purposes because of modern means of transportation. This directory therefore takes on added significance since it is quite comprehensive in its nationwide coverage. There are well over 2,000 names and addresses of special facilities for the exceptional individual. Professional workers, schools, libraries, parents and patients themselves will find this edition as handy as the telephone directory.—ARTHUR LERNER, Los Angeles City College.

HOSPITALIZING THE MENTALLY ILL: EMERGENCY AND TEMPORARY COMMITMENTS

Reprinted from Current Trends in State Legislation, 1955–56

By Hugh A. Ross

Ann Arbor, University of Michigan Legislative Research Center, 1958. 96 pp.

In this extensive article the author presents the results of a study of state legislation on emergency and temporary commitments to mental hospitals. He points out that in general the laws relating to admission to mental hospitals are "cumbersome and archaic"; his aim in the present study is to enable legislative draftsmen to improve on the present procedures. Of this aim all who are interested in the welfare of the mentally ill can heartily approve.

Professor Ross reminds us that there are at least six separate types of admission procedures: voluntary (treated by him in an earlier publication); admission by guardian; nonprotested admission; emergency commitment; temporary commitment; and formal commitment.

As to the second, the state of the law is nebulous and should be clarified by legislation.

Nonprotested admission lies between voluntary and compulsory commitment. At least 9 states have this provision, and it is incorporated in the Draft Act proposed by the United States Public Health Service. The method calls for at least acquiescence on the part of the patient, but avoids the formality of a court commitment. Another advantage is that it encourages early hospitalization.

In emergencies, some method of prompt hospitalization is necessary. Such a right existed under common law, and does still exist in some of the 40 states which have made statutory provision. This is an area in which careful draftsmanship is desirable, for the protection of all concerned.

In less urgent cases, temporary commitment is desirable for observation, and at least 10 states have provided for it. The term of commitment is limited, and the legal formalities should be less rigorous than for ordinary commitment.

One of the confusing and confused questions is that of the effect of commitment (of

any sort) upon the patient's legal capacity. To say that the law is generally unclear on this point is to put it mildly. Too many of the courts seem to reason that insanity means commitment and insanity means incompetency; *ergo,* commitment automatically results in incompetency. Such reasoning works a genuine hardship on many patients; the Draft Act attempts to clarify the situation. To make commitment the equivalent of incompetency operates against early hospitalization and impedes rehabilitation.

Professor Ross approves the Draft Act in general but offers some suggestions for its improvement. Certainly the states would do well to consider carefully the enactment of this proposed legislation as more humane than many of the statutes which now exist. He has given us a scholarly (379 footnotes) and progressive presentation of the facts and the desiderata in a field which contains too much still of formalism and disregard of the welfare of the mentally ill.—WINFRED OVERHOLSER, M.D., St. Elizabeths Hospital, Washington, D. C.

ETHICS, THE PRINCIPLES OF WISE CHOICE

By Charles A. Baylis

New York, Henry Holt & Company, 1958. 373 pp.

In these days of vacillating moral values, it is refreshing to remind ourselves that there is such a field as ethics. Man for himself, a phrase of noble but also insidious implications, releases a kind of moral freedom which can easily abandon standards. The author in a systematic manner discusses ethics as the search for principles of wise choice and reviews the classical arguments. The ethics of duty, personal whim as the basis of choice, the ethics of value, and the problem of responsibility are some of the topics presented.

Today, when religionists and moralists are being compelled to reexamine their cherished assumptions in the light of new insights from psychiatry, psychology, cultural anthropology and sociology, there are bound to be radical conflicts between the older schools of thought and the modern psychological orientation. Our developing knowledge of the unconscious—particularly as it concerns motivation, free will, responsibility, determinism and the need to evaluate our value systems in the light of these new knowledges—greatly modifies many of the traditional approaches to such problems as ethics, morals and religion. The author does not seem to be sufficiently aware of depth psychology, and the problem of the unconscious is almost totally ignored.

We need to relate moral value systems to mental health, but the book makes little mention of this. When the author's discussions relate to psychodynamics, he is most unsatisfactory. His theory is liberal—that is to say, he permits us wide scope in relating duty to religious obligations—and he does us a real service by asking the right questions about behavior. But his answers are unsatisfactory. His ethical theory seems to be that happiness is good, and unhappiness is bad. He is extremely wordy and repetitious in his desire to state the issues, and the reader often gets lost in rather superficial illustrations. His discussions of absolute self reveal a misunderstanding of that term as used by behavioral scientists.

Yet he raises the questions we should want to think about. The answers will be difficult to find and no doubt could never be universally accepted. But can we find the right answers to a system of values when there are so many conflicts among religious and cultural groups? The confusion is

compounded further by the big problems of determinism and unconscious motivation.

The book makes interesting reading for mental health workers who may have forgotten that ethics and morals should be an essential part of personality maturation. The religionist will not be satisfied by the conclusions of the author, but the author compels us to do some serious thinking about some very fundamental things.—GEORGE C. ANDERSON, Academy of Religion and Mental Health.

CASEWORK PAPERS 1957 FROM THE NATIONAL CONFERENCE ON SOCIAL WELFARE

New York, Family Service Association of America, 1957. 158 pp.

This is a volume that should be read by every social worker—not just the caseworker. The aim of the editorial committee was to cover as wide a range of subjects as possible. Accordingly, the 12 excellent papers selected are so diversified that it is impossible to do them justice in this brief review.

In 4 papers specific casework services are discussed. The complexity of the caseworker's role with the unmarried mother is sensitively revealed by G. Leyendecker. A strong and logical plea is made in 3 papers for individual services for the prisoner (by W. Nagel), the mentally retarded child and his parents (by M. Mednick), and children in public assistance (by E. Minton). Miss Minton includes in her article a good but brief review of the development of federally aided programs.

The reports of 2 intercountry projects in adoption of children are not only timely but also extremely interesting. M. Valk writes of adopted Korean children, L. Graham of Japanese. Although these reports reaffirm our theories about adoptions, further research by a team including an anthropologist is undoubtedly needed.

A fine delineation of the supervisor's role in meeting the needs of a first year worker—needs differing from a student's—in a family agency is given by R. Reynolds. New and stimulating ideas for the use of specific allied services are spelled out by P. Margolis for the homemaker service and by M. Collins for the volunteer in serving individuals.

After presenting his convincing arguments for a specific approach in all areas of social work, S. Mencher states that learning experiences related to research should be integrated into the basic curriculum. Discriminating references are included here as well as in other papers, but no bibliography is attached. In the reviewer's opinion, such an addition would have been a valuable aid to students and teachers.

Quite appropriately, the leading article is a brilliant discussion by M. Pumphrey of Mary Richmond's concepts. Following this is M. Friend's "Family Process" in which he discusses some of the same concepts. Can it be that Mary Richmond's fears have been realized? Has the caseworker become too specialized, too involved with deeper insights and lost his identity thereby?

This collection of first-rate papers underlines "that social work has a body of knowledge and theory distinctly its own.—MIRA TALBOT, New York City.

ENVY AND GRATITUDE

By Melanie Klein

New York, Basic Books, 1957. 101 pp.

Melanie Klein is one of the pioneers in psychoanalysis, especially child analysis. Her work has not received the attention in

this country that it deserves, largely because her theoretical work, her metapsychology and techniques are not in accord with the clinical material and findings. Rich, imaginative, thought-provoking, stimulating—and difficult—describe Melanie Klein's writings.

Throughout her work she has emphasized the fundamental importance to the infant of his first object relations—mother and mother's breast. If this introjection takes root in the ego with relative security, the basis is laid for later satisfactory development.

This book deals with a particular aspect of earliest relations and internalization processes rooted in orality—envy. "Envy is the angry feeling that another person possesses and enjoys something desirable—the envious impulse being to take it away or to spoil it. Moreover, envy implies the subject's relation to one person only and goes back to the earliest, exclusive relation with the mother."

Melanie Klein attributes much—too much without scientific evidence—to the pre-verbal period of infancy. Pre-verbal emotions and fantasies appear as "memories in feelings" in the transference situation. The first object to be envied is the feeding breast, which possesses everything the infant desires. It is well known from her previous writings that "if envy is excessive, this indicates that paranoid and schizoid features are abnormally strong and that such an infant can be regarded as ill."

A major derivative of the capacity for love is the feeling of gratitude which is rooted in the emotions and attitudes that arise in the earliest stage of infancy. "It is essential in building up the relation to the good object and underlies the appreciation of goodness in others and in oneself. Gratitude is closely bound up with generosity."

It is not possible in a review to discuss this rich monograph. Her views on early ego, ego-splitting, the onset of guilt, the ramifications of envy, the case illustrations, defenses against envy are clearly presented. Her departures from Freud, and particularly Abraham, are carefully stated.

This is a most interesting, lucidly written book by a great student. No psychoanalyst, no child analyst, should miss reading this work. If other disciplines are sufficiently grounded in psychoanalytic metapsychology, there is no question that they will profit too. One ought to read especially those with whom one disagrees.—JOSEPH D. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

DISCOVERING OURSELVES

By Edward A. Strecker and Kenneth E. Appel

New York, Macmillan Company, 1958. 3rd ed. 303 pp.

This book, revised in a 3rd edition 27 years following its original publication, discusses the fundamentals that must be considered in any attempt to seek some of the answers to the psychological aspects of living. Such are the intimate relationship of the body-mind, the elementary concepts of psychology, sensation, perception, thinking, emotion, etc.,—all channeled to the ultimate objective of action. From this the book progresses through an explanation of the conscious and unconscious factors in behavior to a discussion of the personality development. This latter is along Freudian concepts, yet the book's general tone does not stress psychoanalytical approaches.

Part 2, charting a course, describes in considerable detail the nature of emotion

and the ramifications of such widespread and basic emotions as anger and fear. Then are taken up fundamental mental mechanisms—rationalization, repression and others. The author also gives a resumé of the clinical conditions in which energy at the emotional level manifests itself in the symtom groupings known as hysteria, neurasthenia and anxiety states. A chapter on the so-called inferiority complex, followed by sublimation, completes the book. An interesting feature is the appendix, with thought-stimulating questions on the various chapters and a series of searching questions aimed at promoting self-analysis.

This reviewer considers the work as excellent—clearly stated and utilizing the maximum of vocabulary known to the educated non-medical reader. Cases are cited but these are briefly given in concise terms. They illustrate without becoming elaborated case studies. In the main it would seem that formulations are presented with vigor and yet without the dogmatism that excludes other notions. In this process there will be implied assumptions that intellectual understanding can do more than it probably can. This is inevitable. When we talk about our mental functioning, it is natural to assume that concepts themselves, as concepts, are capable of carrying much of the load that is always at a non-intellectualistic and non-verbal level. Yet try to think and understand we must, and we cannot do it without words and intellectualistic constructs.

The authors have had experience as clinicians and teachers in Philadelphia, one of the foremost medico-psychiatric centers, over several decades and there they have distilled much of this experience. This reviewer knows of no book for the layman that he considers more sound and forthrightly written.—FORREST N. ANDERSON, M.D., Van Nuys, Calif.

MARRIAGE COUNSELING: A CASEBOOK

Edited for the American Association of Marriage Counselors by Emily H. Mudd and others

New York, Association Press, 1958. 488 pp.

This is a sober and conscientious book which presents 41 case reports of counseling experiences with a wide variety of marital and pre-marital problems. The reports are written by 38 different members of the American Association of Marriage Counselors, but the authorship of each case is not revealed to protect the anonymity of the clients. Most of the authors received their primary training in the behavioral and social sciences—sociology, social work and psychology. Five are physicians—three gynecologists and two psychiatrists (a surprisingly low representation of the latter!).

Some of the general areas covered by the case reports are youthful marriages, dominance and submission in marriage, problems of sexual adjustment, the triangle in marriage, neurotic interaction, premarital counseling, sex problems of engaged couples, problems of mate selection, and cultural differences as they relate to the choice of a marriage partner.

Included also are two relatively brief but thoughtful introductory chapters on marriage in the United States today and the principles, processes and techniques of marriage counseling, and two concluding chapters on marriage counseling today and tomorrow.

The emphasis in the chapter on principles, processes and techniques is that "the marriage counselor deals more often with so-called normal, average people" and that therefore "the marriage counselor who is not a psychiatrist and who has no special training . . . should not indulge in extended

analyses or attempt fundamental personality changes." Moreover, he "must make certain, so far as possible, that he is not dealing with a deep-seated psychotic or neurotic behavior manifestation with which it is beyond his ability to cope" and he must "be prepared . . . where needed . . . to lay the groundwork for a constructive psychiatric referral."

The book should be of interest not only to marriage counselors but to all who come into contact with marital and family problems in the course of their work—social workers, probation officers, psychologists, physicians and others. Even the trained psychiatrist, though he may find most of the material relatively familiar, may discover much in the case material that is stimulating and provocative. It is regrettable that the editors did not see fit to provide an index.—JUDD MARMOR, M.D., Beverly Hills, Calif.

SOCIAL PSYCHOLOGY: AN INTRODUCTION TO THE STUDY OF HUMAN RELATIONS

By S. Stansfeld Sargent and Robert C. Williamson

New York, Ronald Press, 1958. 2nd ed. 649 pp.

The first edition of this text (1950) was subtitled "An Integrative Interpretation"; the recent one purports to be "An Introduction to the Study of Human Relations" designed for intermediate courses in psychology, sociology, social science survey and human relations courses. The first edition was a solo performance by psychologist Sargent; the second is a joint effort with another psychologist, Professor Williamson.

The new edition is by no means a thorough revision; yet it brings the first book up to date and adds 4 new chapters: on group dynamics and its applications, ethnics relations and prejudice, social psychology and international relations, and the present and future of social psychology. The last two of the added chapters, however, show little depth in the unprecedented era of the atom.

The authors define social psychology as "the scientific study of persons as members of groups with emphasis on their social or interpersonal relationships." So far, so good. But why limit this expanding field to interpersonal behavior, in the new age of intercultural and intersocietal relationships?

While this textbook comes closer to a genuinely interdisciplinary point of view than most of the three-score texts published during the last fifty years, it nevertheless stops short of a complete synthesis of the behavioral sciences, especially in its failure to relate the pertinent findings of physiology, neurology and psychiatry to a discussion of the development of personality and character.

Nevertheless, the second edition, like the first, has much to commend it as a good source book supporting an undergraduate orientation course in human relations; it is clear, well-written and carefully documented with useful references. Like so many textbook revisions, however, it is longer (by 130 pages), larger, heavier and, of course, costlier than the original.

Experienced teachers of social psychology are still hoping to find a smaller book with a more daring hypothesis, in keeping with the expanding scope and the growing importance of the field. "Men grow," said the late Professor Whitehead, "in an attempt—however unsuccessful—to conceive of the whole of reality at one sweep."—ARTHUR L. BEELEY, University of Utah.

POPULATION IN ITS HUMAN ASPECTS

By Harold A. Phelps and David Henderson

New York, Appleton-Century-Crofts, 1958. 512 pp.

It is through the light they throw upon the social systems which generate them that population data achieve their own interest. In this book, one of a sociology series, the authors have set out to interpret basic population data in these terms, and to a large measure they have succeeded. Inevitably in a work of wide scope there is some unevenness, and the whole book suffers somewhat from lack of an over-all, coherent, theoretical framework, but the general result is clear, competent and more than ordinarily interesting.

There are 6 main sections. The first is concerned with the number of people in the world through time and across the face of the earth, with emphasis upon the United States. The second part examines the ways in which Americans distribute themselves in city, suburb, town and country—and of course the social processes underlying this distribution—while the third section deals with their racial and ethnic origins. The fourth part examines the stability of the composition of the population—its age, its family patterns, its education, its religion and occupation. The fifth deals with various aspects of physical, psychological and social health. Part 6 is composite and is concerned with predictions of the future as well as with an historical appraisal of the great men of demography. Finally, it deals with the question which has been latent in the book all the time: "What's to be done about the population of the world?"

At this point the authors make explicit the moral and philosophical assumptions which have been evident through the book, and formulate very clearly the problems of population planning. This is an excellent idea, for in the social sciences, when it is impossible not to evaluate, it is best to make clear the standards of judgment used so that the reader may accept them or reject them as he pleases. In this case they are ethical-humanistic standards and sit well—at least with this reviewer.—ELAINE CUMMING, New York State Department of Mental Hygiene.

THE PSYCHIATRIC HOSPITAL AS A SMALL SOCIETY

By William Caudill

Cambridge, Harvard University Press, 1958. 406 pp.

In the past five years you have perhaps read Jones's *The Therapeutic Community,* Stanton and Schwartz's *The Mental Hospital,* the Greenblatt-York-Brown study titled *From Custodial to Therapeutic Patient Care in Mental Hospitals,* Belknap's *Human Problems of a State Mental Hospital* and the Greenblatt-Levinson-Williams symposium on *The Patient and the Mental Hospital,* to say nothing of a long list of journal articles. You might easily conclude that you should not spare time to read still another book about the psychiatric hospital as viewed in social science perspective. This reviewer begs you not to come to that conclusion. Once you begin William Caudill's exceptionally well written and carefully studied volume you will undoubtedly discover that, although it deals with many of the basic problems discussed in the earlier publications, it adds *much* both in conceptualization and in description of research methods. What it adds is of great value to all categories of personnel—clinical psychologists, psychiatric nurses and social workers as well as psychiatrists—who are struggling

with the task of how to make the mental hospital truly a therapeutic community. Moreover, the final chapter, The Possibility of a Clinical Anthropology, indicates an evolving role in connection with that task for the anthropologist and by implication for other kinds of social scientists.

The purpose of the book is to explore the social system of one small psychiatric hospital to attempt to discover the meaning of that system both for patients and staff. Emphasis has been placed on three broad areas of life within the institution which Dr. Caudill has designated as therapy, administrative care and human relations; on the status, roles, values and beliefs of the various categories of staff; on the flow of communication throughout the institution; and on the resulting patterns of interpersonal relations and group interaction.

The principal methods used for obtaining data were direct observation and interviewing. Caudill's earlier indirect observations, made through assuming for two months the role of a patient, unquestionably contributed to the direction and depth of these methods. Over 300 hours were spent in observation on the men's locked ward and an equal amount on two open wards. (As a consequence he suggests that residents should spend much more time on wards, and for a limited time should live on them.) For several months he kept detailed notes of what occurred at the semiweekly clinical case conferences and also at the daily staff administrative conference attended by senior psychiatrists, residents, supervisory and staff nurses, the social worker and the occupational therapist. Interviewing was used extensively through a technique of showing pictures of hospital life, which are reproduced in the text, both to patients and personnel individually, with the request that they comment on the content of the pictures.

Caudill's method of presentation of his considerable data is skillful. By permitting the reader to follow individual patients and staff through various situations he makes the text not only intensely interesting, but enables one to view the same problems progressively within different contexts until their significance for the particular hospital (and perhaps for hospitals generally) can scarcely be questioned. In a block of three chapters entitled Influence of Hospital on Doctor-Patient Relationship, Misunderstandings in Administrative Decisions, and Occurrence of Collective Disturbances the focus of attention is upon these aspects of hospital life. At the same time interaction is viewed as increasingly wide in scope: it moves from the physician and patient, to a small group on the ward, to the whole hospital.

The next four chapters deal with perceptions of the hospital as gained from the picture interviews. From them emerge patterns of agreement and disagreement that characterize the ways in which physicians, nurses and patients see the three areas of hospital life and the types of social interaction. Then follows a section on the day-by-day administrative operation of the hospital as determined by the staff meetings Caudill attended. The importance both of status and role in determining what was expressed at those meetings, and how, is emphasized by careful documentation, much of it precise enough to be recorded quantitatively.

From the wealth of material presented space permits us to select only enough of the interrelated themes to suggest the nature and quality of the work.

In reference to the three broad areas of life—therapy, administrative care and human relations—as they were delineated in the hospital at the time it was studied, Caudill makes the following comments. Physicians were primarily concerned with

therapy, discontented if too much time was spent in administrative duties, and frequently uncomfortable in informal human relations with patients. Nurses generally saw themselves as carrying out administrative orders, directed most matters that they defined as therapy to the doctors, and were often uncomfortable in human relations with patients. Patients structured their contacts with each other in terms of human relations, and tended to be uncomfortable when the doctor or nurse stepped out of the therapeutic or administrative role.

Even if emphasis be focused exclusively upon the therapeutic aspect of hospital life, progress in therapy is not solely a matter of relations between doctor and patient. The administrative and the therapeutic process are intimately linked. Difficulties among staff are likely to be reflected in disturbed patient behavior. Perhaps emotional information is transmitted with fewer cues than is cognitive information. Feelings can run through a hospital rapidly. As a consequence, Caudill saw indications of what he designated as "ground swells" which seemed to result in all patients tending to do fairly well at one time and less well at another.

As perceived by the author the hospital under consideration provided several potential sources of satisfaction to which a patient might turn to obtain help with his immediate needs. They were his physician, the nurses and aides, the physical space and facilities of the ward used in ways he found comfortable, other patients, and his own inner resources. The staff took account, however, of only a few of these sources in its effort to understand and help the patient. The communication system provided primarily for the transmission of information about his relations with the medical and nursing personnel. Significant clues about the patient were lost because of lack of awareness of the importance of all sources of satisfaction, particularly during the crucial period of his first days in the institution.

The physician was likely to be so concerned initially with the patient's history and underlying conflicts that he failed to use advantageously what he might have picked up at the therapeutic sessions about relations with nurses, other patients or the physical environment. The physician, moreover, frequently failed to consult nurses on the wards about these matters, and the latter offered little information at staff meetings, partly because of their status and partly because they had not been charged with responsibility for sharper observation of how patients used potential sources of satisfaction.

The "mobility-blocked" system of the hierarchically structured hospital was the cause of grave difficulties in communication. The amount of talking at staff conferences was directly related to the status of the discussants. Thus, at the conferences observed, senior physicians talked more than residents and four times more than nurses. Even the rather passive resident who spoke the least talked more than the dominant supervisor of nurses. The latter expressed herself, however, more frequently than the staff nurses.

When trying situations arose, like that described in the chapter called Occurrence of Collective Disturbances, all categories of staff had difficulty in communicating with each other. The senior staff appeared to withdraw from the daily routine of decision-making, the residents restricted their focus to their own patients and reduced their interest in the work of the hospital, while the nurses decreased the little they ordinarily said in staff meetings and increased the formalization of their routines. (The patients, meanwhile, increased their intra-group relations and assumed more inde-

pendence in planning their daily activities.) Communication among staff was often charged with expressions of hostility and punitiveness, and little psychological support was accorded either residents or nurses.

Failures in communication detracted from consistent unified planning. Each category of staff tended to work within his own compartment, often with minimum exchange of pertinent conversation. From his observations Caudill noted, for example, that different combinations of staff on duty seemed to produce different effects on diagnostic or social groupings of patients. The combinations found, however, were purely accidental because the chief resident and the nursing supervisor independently scheduled who should be on duty. Whether the therapeutic potential of the hospital could be increased through careful joint planning and experimental testing of ward staffing patterns received no attention.

Caudill concludes: "The conflicts between individual staff members, or between role groups in the staff, are often as important for the understanding of the nature of a problem in the hospital as are the actions of particular patients. If the goal of a therapeutic community is to be reached, there must be a greater openness among staff members than is usually the case at present, and a willingness on the part of the staff to examine their own motivations rather than to project problems onto the patients. This is, perhaps, asking for a good deal, but if it is expected of disturbed patients it is possibly not too much to ask of those who are better integrated. In order to achieve such a state of affairs, however, changes in the organization and atmosphere of the hospital must be made so that neither staff nor patients are punished for their efforts at greater openness and understanding" (pp. 332–33).—ESTHER LUCILE BROWN, PH.D., Russell Sage Foundation.

ANALYZING PSYCHOTHERAPY

By Solomon Katzenelbogen

New York, Philosophical Library, 1958. 126 pp.

This is a diminutive volume which bears a catchy, though misleading, title. It does not offer an analysis of psychotherapy. It is, as the author quickly reveals, "what I practice in psychotherapeutic sessions." It is the author's orientation to the task of psychotherapy, influenced by the psychobiological concepts of Adolf Meyer. "This small book has a big goal." Its purpose is to enlighten patients and prospective patients; it aspires to neutralize the tendency among lay people to equate all psychotherapy with the Freudian method.

The author's conceptual approach to psychotherapy is eclectic. He concerns himself with a range of pertinent themes: the problems of rapport, the variety of techniques, the results of psychotherapy. As is to be expected, he expresses a pointed criticism of some central features of the Freudian analytic method.

Psychotherapy is "talking treatment." It is a 2-person relationship with a special purpose. To fulfill this purpose a therapist requires knowledge of medicine, biology, psychology and sociology. He should have an interest in people, be a good listener, be mature, objective and also be amply endowed with *savoir faire.* His main task is the direct dealing with the patient but the therapist must also concern himself with the environment.

In his critical discourse on Freudian analysis the author raises questions concerning the tendency to overemphasize unconscious mental forces. He believes the importance assigned to sex and childhood conditioning is one-sided and that life experience in adolescence and adulthood may also be crucial to personality disorders. He

is impatient with the "couch" and with the passive role of the analytical therapist. The final chapter on psychotherapy and science is seriously inadequate.

As is the case with all discussions of psychotherapy today, inevitably personal preference and bias play a part. In this book there is some risk also from oversimplification.

The author's urge to discipline himself to an explicit commitment concerning his conception of psychotherapy is commendable. Too few people in the field are willing to divulge what they do.

Despite the author's express wish to be brief and simple, the tone of the book is somewhat pedantic and does not succeed in clearing the air on these many unsolved problems. Angyal once said that "psychiatry is the application of a science which does not yet exist." The practice of psychotherapy is still in great part a personal art. We aspire to give it a scientific foundation but this is still in its birth pangs. The conceptual developments of recent years which permit a more precise formulation of the dynamics of interactional and communication processes offer considerable promise. These more recent studies are not alluded to here. This small book, which sets for itself a "big goal," unfortunately does not offer much enlightenment.—NATHAN W. ACKERMAN, M.D., New York City.

CURRENT STUDIES IN PSYCHOLOGY

By F. J. McGuigan and Allen D. Calvin

New York, Appleton-Century-Crofts, 1958. 226 pp.

This volume was designed as a supplementary text for introductory psychology courses. The editors seek to "provide the beginning undergraduate student with an opportunity to become familiar with some of the current (since 1950) trends in psychological research." They have chosen pure rather than applied studies and have included difficult experiments, but their selection of areas and topics reveals broad interests leaning toward personality, clinical and social psychology.

After a few pages on experimentation and scientific procedure in psychology, the reader starts in on learning studies involving several types of conditioning; compared with much of the experimental work in this area, however, the emphasis is upon human rather than animal research. The section on motivation contains 6 studies, including 2 on anxiety and the relieving of anxiety and one on "the measurement of experimentally induced levels of sexual motivation by a projective test." Part III, on development, starts with a study on the growth of intelligence and moves on to a phase of class differences in child-training practices and an evaluation of sex hormone replacement in aged women. Studies of "facial vision" and of reduced general stimulation on the human being are found among the offerings on perception. The section on personality and behavior disorders has papers on hypnotic age regression, the Eve White case of multiple personality, an assessment of round-table psychotherapy, an experimental study of displacement and two other studies. The five selections on social psychology include research on conformity and character and on interpersonal attitudes of former Soviet citizens, and an analysis of the effectiveness of psychological warfare.

An appendix relates the readings to eight current elementary texts in psychology.

Psychologists are sometimes considered extreme "eager beavers" owing to the stupendous number of research studies, both significant and insignificant, that they pub-

lish. Certainly their output makes the job of selection a difficult one for teachers and for professional workers in allied fields. The editors of *Current Studies in Psychology* are to be congratulated for assembling a group of up-to-date and significant pieces of research which should open the reader's eyes to the wide scope of psychological endeavor.—S. STANSFELD SARGENT, PH.D., VA Hospital, Phoenix.

MOTHER AND CHILD: A PRIMER OF FIRST RELATIONSHIPS

By D. W. Winnicott, M.D.

New York, Basic Books, 1957. 210 pp

The author, a pediatrician and psychoanalyst, addresses his book to the "ordinary, devoted mother." He aims at helping her recognize the importance of her emotional attitude in caring for her young child. He avoids giving restricting advice and telling her what to do or how to feel. His goal is to uncover the genuineness of her feelings, her innate natural knowledge of how to relate to her infant.

In this he succeeds to a large extent. The whole tone of the book is warm and delightfully simple. The many tasks of child care are discussed in situations which confront every mother, including everyday "problems" like jealousy, stealing, telling of lies, and minor illnesses. The author succeeds in delineating the normal range of such deviant behavior from the manifestations of abnormal development.

From what has been said thus far this book should be an ideal companion for the modern young mother. Unfortunately, this it is not. The book is based on talks which were given during the war years over the British Broadcasting Company. It is amazing to note the wide gulf between the problems of the intelligent young mother in England at that time as compared with what her up-to-date counterpart in America is struggling with today. The straw man of Winnicott's humanistic psychoanalytic approach to motherhood is the "scientific pediatrician" who seems to be bent on repressing a mother's normal feelings, making her approach her baby as if it were a mechanical object. I do not know whether the British pediatrician is, or ever, was such a *bête noir*.

His American colleagues in 1958 would be puzzled by the rigid prescriptions against which Winnicott protects the British mother. In the U.S. the emphasis on permitting emotional expression and indulgence of an infant's needs has been propagated so forcefully that a young mother is faced with the very opposite problem—namely, of producing feelings as a command performance. The resulting perplexity of young parents prompted the reviewer to write a book, seemingly along the same lines as Winnicott's—namely, of helping mothers to look upon their task with trust and confidence and of protecting them from unreasonable "scientific" demands which here, in the U.S.A., were forced upon her by aggressive psychological experts.

There is one inner inconsistency in this stimulating and reflective book: The author states repeatedly that he, a mere man, could never really understand and know how a mother feels about her child, her own flesh and blood. At the same time the book abounds with definite statements and vivid descriptions on how "the infant" feels or what "the baby" experiences or expects in any given situation. This anthropomorphism is the more astounding because the difficulty of knowing another person's feelings has been so clearly recognized.

Winnicott's book is of historical and cross-cultural interest, reflecting the struggle to

find a sound balance between the physiological and psychological aspects of child care.—HILDE BRUCH, M.D., New York City.

LOVE, SKILL AND MYSTERY: A HANDBOOK TO MARRIAGE

By Theodor Bovet

New York, Doubleday & Company, 1958. 188 pp.

Dr. Bovet, a Swiss physician who has apparently specialized in marriage counseling, wrote a previous book on this subject in 1947, *Marriage, Its Crises and Potentialities.* This text, written in German, was revised in 1956 and republished in Europe where, according to the dust cover statement, 100,000 copies have been sold. It has now been translated, and quite well, into English, and was published in this country in June 1958.

It is quite evident from reading the book that the author is well-informed, has had wide experience, is something of a philosopher as well as a physician, has very definite convictions, and is a deeply religious man. Furthermore, he writes well, and his book is quite readable. There is a great deal of practical information, wise advice and inspiration for young unmarried people, the newly married, and the long-married, and one welcomes this small volume as a thoughtful contribution to the literature on marriage. There is very little psychiatric terminology, although the author appears to be fairly well informed about dynamic psychiatry. He quotes only one psychiatrist, Dr. Helene Deutsch, and her only once, but there are many quotations from sociologists and other marriage counselors, and a great many Biblical references.

Dr. Bovet's convictions include complete opposition to premarital coitus—even to sexual arousal before marriage—and practically complete opposition to divorce. His strong position is that marriage is not to be entered into lightly in the first place, and that marriage is for life. One would doubt, from reading his book, that he would ever regard a marriage, however much it might seem to be on the rocks, as unsalvageable. In these views he takes a profoundly religious point of view, probably more Catholic-oriented than Protestant-oriented, although in one section he tries to show that the Catholic and Protestant views about divorce are much closer than is usually supposed. At some points in his exposition, particularly in the last two chapters, he displays a religious devoutness that may, to some readers, somewhat obscure the advice he is giving. "Following God's will" in various marriage crises may prove to be rather nebulous advice for many people who are troubled about their marriages.

Throughout the book, however, there is a wealth of practical advice, earthy wisdom and clear information. Contraceptive methods are explained in detail, coital positions are described, and techniques of love-making are explained; there is even a proposal, though an autosuggestion fantasy, for control of timing of the husband's orgasm—given as a possible cure for *ejaculatio praecox.* He includes the clearest explanation of the Rh factor in layman's language that this reviewer has ever seen. His view about hereditary factors, especially about the inheritance of mental illness, may be too organically weighted for some readers, as it was for the reviewer, and may unduly alarm many people who have experienced mental illness or whose near relatives have.

With the few reservations noted, however, one may safely recommend this book to young people contemplating marriage, to happily married couples and to couples who

are worried about their marriages. All will find it deeply thoughtful, rich with both down-to-earth and inspirational wisdom, and genuinely helpful.—ROBERT P. KNIGHT, M.D., Austen Riggs Center, Stockbridge, Mass.

THE STORY OF HUMAN EMOTIONS

By George M. Lott

New York, Philosophical Library, 1958. 225 pp.

Dr. Lott has written a book for the general public describing the development of the human personality and explaining why people feel and act as they do. His stated purpose is to lead his readers to their optimal personal social adjustment through an understanding of themselves. He writes from a background of many years' clinical experience as a psychiatrist and counselor of young persons.

The volume, as a whole, covers the subject in fairly comprehensive fashion, in language which is refreshingly free of technical terminology. The points Dr. Lott wishes to make are abundantly illustrated with anecdotes and case material. A generous sprinkling of cartoons, largely from well-known popular magazines, highlights some of the more important topics.

This is, of course, one of many books dedicated to a similar purpose, and the reader inevitably looks for its particular significance in a heavily competitive field. The subtitle suggests that it is written from a "teenage viewpoint," but this is by no means obvious as one carefully reads the numerous chapters. Much of the material follows a fairly conventional path of advice to parents about their children.

While the book as a whole covers most of the important points regarding human emotions, the individual sequences and transitions of individual passages are not always clear. The arrangement of subheadings is particularly inconsistent. Throughout the book, generalizations are frequently obscured with a barrage of anecdotes and quotations which seriously detract from the clarity of the total presentation. There are numerous humorous references, many of which highlight particular aspects of the material in a very helpful way. However, the humor is likewise inconsistent and ranges from the light to the heavy, the relevant to the farfetched.

A most unfortunate chapter a third of the way through the book, contributed by a collaborator and purporting to summarize previous material, includes numerous terms such as "diabolical brats" and parents who "have made a mess of the child already." This section is quite out of tune with the tenor of the whole volume, and one wonders why it was included.

Dr. Lott has made a serious and sincere attempt to discuss human emotions in such a way that the reader may derive personal assistance from what he peruses. The success of the volume would appear to hinge on whether or not the author's particular mode of presentation is clear enough and forceful enough to really impress those whom he addresses.—CHARLES BRADLEY, M.D., University of Oregon Medical School.

CLINICAL STUDIES IN CULTURE CONFLICT

Georgene Seward, ed.

New York, Ronald Press, 1958. 598 pp.

In the behavioral sciences and art it has always been stressed that a person can be understood only by recognition and appreciation of all of the forces which have been interacting to make him the individual that

he is. The training program of social workers frequently utilizes study of actual case records which emphasize such factors as cultural characteristics to illustrate how these are integrated into the personality structure. Now there has been published a volume which serves the same purpose for the clinical psychologist in training.

Clinical Studies in Culture Conflict, edited by Georgene Seward, Ph.D., consists of 22 case presentations by a number of psychologists, psychiatrists and social anthropologists. The patients range from an English war-bride coming into an American-Armenian family to a Navajo Indian who was a quadriplegic as the result of an automobile accident. By case histories, detailed protocols and in some instances therapeutic progress reports, the reader is given valuable insights into the interplay of forces which resulted in the particular individual under study. One sees the character structure in a new dimension and thus can more clearly define how help might be given.

It must be pointed out that this book does not attempt to show the development of specific character structure in the matrix of a particular culture or as the result of cultural stress. This apparently was done by the editor in a previous work and the present volume then becomes a series of illustrations for that study. It may well be that the two volumes should be read together to obtain the maximum usefulness from both.

Since the emphasis here is on cultural conflicts, one should not perhaps ask for more. However, it is the reviewer's opinion that the focus on cultural clash is not sufficient and one must also elaborate on the interaction of cultures with growth and the appearance of new qualities. With such an approach, the editor might have avoided the gross error of his statement that "the Negroes have no specific culture of their own, beyond the forgotten echoes of African drums . . ." The interpenetration of the African and American cultures in the formation of a unique Negro culture is a fascinating story which has been repeatedly told.

There are statements in this work which struck the reviewer as rather rigid and too close to stereotypes to be comfortable. However, one can be more impressed by the warmth of feeling for the patients which shows through the histories and data, and thus the end result is a definite contribution towards the aiding and benefiting of the troubled.—LEO H. BERMAN, M.D., Green Farms, Conn.

INTERDISCIPLINARY TEAM RESEARCH METHODS AND PROBLEMS

By Margaret Barron Luszki

New York, New York University Press, 1958. 355 pp.

This timely volume is concerned with interdisciplinary research, including its definition, the advantages and disadvantages of such teamwork, as well as the theoretical aspects and practical details involved in interdisciplinary studies. The choice of the term *interdisciplinary* rather than *multidisciplinary* is apparent because of the interactions between proponents of different fields implied by the former. A team of investigators can tackle larger problems than can individuals; time is saved and more variables can be controlled by the simultaneous efforts of a group.

The author wisely reemphasizes the different viewpoints of scientists and practitioners as a possible cause of friction. The scientist is ready to go contrary to accepted standards, while the medical man will do nothing to jeopardize the patient. The author concludes that "unless structural

ways can be found to circumvent this difficulty, any group projects which involve asking therapists to do research is likely to come to grief."

Specific training is advised for interdisciplinary work. Such training can readily be accomplished at the graduate level but is not a part of the training for the M.D. degree, and the problem of training psychiatrists for interdisciplinary research is therefore more difficult.

Among the practical problems considered is the task of selecting people for participation. The author concludes that it is desirable for each member of the team to be somewhat dissatisfied with the limits of his own discipline and to feel the need for collaboration. The responsibilities of the research leader, the difficulties of administration and the choice of the administrator are also analyzed.

From this enumeration of some of the high spots of the volume, it can be seen that it is essentially a thoughtful consideration of many of the questions concerned with a method of investigation which is widely employed. The book is recommended reading for all investigators and administrators involved in interdisciplinary teamwork. A valuable bibliography classified according to subject is included.—HAROLD E. HIMWICH, M.D., State Research Hospital, Galesburg, Ill.

ORTHOPSYCHIATRY AND THE SCHOOLS

Morris Krugman, ed.

New York, American Orthopsychiatric Association, 1958. 265 pp.

In spite of its multidisciplinary approach and its great concern with children, "orthopsychiatry has been overwhelmingly involved in clinics, hospitals, treatment centers and social agencies, and only obliquely concerned with schools," Dr. Krugman says in his introduction to *Orthopsychiatry and the School.* Krugman makes the further comment that even when orthopsychiatry did deal with schools, "it was generally to tell schools what to do for specific children under study or treatment by a clinic or team."

This volume should be of practical help to people in education who are concerned with mental health and what schools can do about it. The 26 papers in the volume are organized in 5 sections: orthopsychiatry's help to education; orthopsychiatry and problems of learning; orthopsychiatry and school mental health; teacher education and mental health; and orthopsychiatry and adolescent problems. Two of these sections were symposia at the 1956 and 1957 meetings of the association.—W. CARSON RYAN, Chapel Hill.

Notes and Comments

RESEARCH

The second list of grants made by the National Association for Mental Health under its expanding research program have been announced by Dr. William Malamud, research director.

The grants were made to 8 research scientists by the NAMH research committee at a meeting June 22. The names of the investigators, the titles of their projects and the amounts of the grants follow:

- Dr. Martin L. Pilot, Yale University, $1,000 for a study of discordance in the development of certain mental and physical illnesses, particularly psychosomatic illnesses, in identical twins.

- Sarnoff A. Mednick, University of Michigan, $11,867 for an investigation of learning and thinking in schizophrenia.

- William E. Broen, Jr., and Lowell H. Storms, Neuropsychiatric Institute of UCLA, $4,538 for research relating behavior theory to schizophrenic thinking.

- Dr. Justin M. Hope, New England Center Hospital, Boston, $15,000 for a study of aldosterone excretion in behavioral disorders.

- Dr. Floyd S. Cornelison, Jr., University of Oklahoma School of Medicine, $12,000 for a study of the effects on mental patients of a sound-film record of their own abnormal behavior.

- Joseph J. Noval and Arthur Sohler, New Jersey Neuropsychiatric Institute, $5,300 for an investigation of the metabolism of adrenochrome and adrenolution in animals and man.

These grants bring to $98,444 the amount allocated by the NAMH research committee since its inception a year ago.

CARE AND TREATMENT

From the *New York Times,* June 24, 1959: "The State Department of Mental Hygiene reported today that a decentralization program was being undertaken at Pilgrim State Hospital in West Brentwood, L. I.

"The objective, according to Dr. Paul H. Hoch, the commissioner, is to achieve the advantages of a small hospital within the framework of a large institution.

"Pilgrim has 14,000 beds and is considered to be one of the largest institutions of its kind in the world. Under the new plan, the hospital will be broken up into several small coordinated hospitals, a cluster of units with 2,000 to 3,000 beds each.

"Each unit will be supervised by an assistant director who will perform both clinical and administrative functions. Each unit will be self-contained, with its own admission service, treatment facilities and release procedures. However, such institution facilities as transportation, maintenance and the business office will be shared.

"Two of the small units already have been established, and it is hoped that five more may be operating shortly."

* * *

The first patients would be admitted shortly to New York's state research unit in narcotic addiction, Commissioner of Mental Hygiene Paul H. Hoch revealed in June.

There are 55 beds for inpatients at the research center, Dr. Hoch said. In addition, about 150 outpatients will be treated. In the course of a year several hundred patients can be treated.

The unit, located at Manhattan State Hospital, Wards Island, New York City, is the first full-time narcotics research unit in the state combining laboratory, outpatient and inpatient operations. It has been

organized for research purposes and will concentrate on basic investigations in an effort to determine primarily the causes of narcotic addiction and to develop better treatment methods. The work of the center will be integrated with the new program of treatment and clinical research to be conducted by New York City.

"In addition to the social and psychiatric problems in drug addiction, which are to a considerable degree known, this research will concentrate on biological factors to try to find a clue to the craving for drugs," Dr. Hoch said. "It is this aspect of the addiction which offers the most challenging problem and the one that must be solved if drug addiction is to be controlled."

* * *

A special project combining group counseling of trouble-susceptible adolescents with parent education for their mothers and fathers has been set up for 5 Long Island communities. The project is a joint enterprise of the Mental Health Association of Nassau County, N. Y., the Nassau County Mental Health Board, the North Shore Child Guidance Center and the school systems of Great Neck, Manhasset, Port Washington, Roslyn and East Williston.

Immediate help is offered to troubled boys and girls from 14 to 16 who would not ordinarily be reached by any counseling service. Families who can afford it are charged a modest monthly fee based on their ability to pay.

The teen-agers meet once a week in groups of 7 to 9. Their parents attend monthly sessions. The schools are taking the responsibility of case-finding and make the initial arrangements with the adolescents and their parents.

* * *

Further confirmation that penicillin is effective against syphilitic psychosis was reported in May in the *Archives of Neurology and Psychiatry*.

More than 80% of persons whose brains are damaged by syphilis can return to work if they receive penicillin in the early stages of the brain damage, a new study has shown. Even the severely affected or institutionalized patient has one chance out of three for improvement and rehabilitation if given penicillin.

The study, dealing with 1,086 patients suffering from brain damage (paresis) covered more than five years and was conducted in eight major hospitals.

Penicillin is the standard treatment for syphilis and if given early will prevent paresis altogether, the report said. None of the 1,086 patients had received penicillin for early syphilis.

The study showed that in most instances only one course of treatment with penicillin is necessary to favorably affect the course of paresis. Retreatment appears to exert little effect.

The effect of penicillin on individual symptoms and signs of paresis are, in general, "strikingly beneficient," the report said. Disorientation, depression, convulsions, tremors, incontinence, impaired handwriting and other symptoms were greatly improved by the use of penicillin. However, impairments of speech, insight, calculation, judgment and general information do not entirely disappear, the report said.

Nevertheless, many patients with paresis can be rehabilitated and returned to work. The sooner the diagnosis is made and treatment begun, the better the chances of the person returning to a fairly normal life, the report said.

The senior author of the report was Dr. Richard D. Hahn of Johns Hopkins Hospital, Baltimore.

* * *

The Veterans Administration is changing its mental hospitals into "open-door" treatment communities, the agency announced in August.

A large number of the patients live and work at the hospitals and come and go about the hospital grounds and towns nearby, much as they would if they lived in any community, while they continue to receive hospital treatment.

Dr. Jesse F. Casey, director of the VA psychiatry and neurology service in Washington, D. C., said the development is in line with the best modern concepts of psychiatry and is doing a great deal of speed recovery of patients. He said "open-door" mental hospitals have reported fewer patients leaving against medical advice, fewer acts of hostility, and higher discharge rates than "closed" mental hospitals.

The VA "open-door" policy is backed by an active treatment program involving extensive orientation of the entire staffs of the hospitals and assistance of volunteers from nearby communities, Dr. Casey said.

However, he said not all patients are able to accept the responsibility of more freedom, and therefore it is necessary for the hospitals to maintain supervision for these patients in closed wards. Granting of the maximum practicable amount of personal freedom is a major factor in rehabilitation of psychiatric patients, Dr. Casey explained, as it gives them opportunity to learn to make their own decisions and adapt to new situations. Many are able to participate in work-therapy assignments and make occasional visits to their homes as a preparation for return to life outside the hospital, he added.

Some 20,000 patients are treated each month at VA mental hygiene clinics as outpatients. More than 65 VA general medical and surgical hospitals have sections for short-term treatment of psychiatric patients.

REHABILITATION

Continued efforts by the New Jersey Association for Mental Health to bring about the deletion of the word *physically* from the name of the Governor's Committee on Employment of the Physically Handicapped have been successful.

* * *

Placement of recovering mental patients in foster homes is now giving the Veterans Administration the equivalent of a 1,500-bed mental hospital, the VA reported last May.

The agency's foster home program was started in 1951 to expand its psychiatric rehabilitation program, especially for veterans hospitalized for a long time. It allows recovering mental patients to live in a home environment as a step in their return to the community.

The VA said 1,554 patients lived with "adopted" families in private homes near VA hospitals during 1958, a 24% increase over the 1,249 in foster homes in 1957 and a 53% increase over the 1,011 in foster homes during 1956.

The hospitals placed 807 patients in foster homes during 1958. A total of 328 of these recovered sufficiently during the year to be discharged from the hospital rolls.

TRAINING

As part of the national trend toward providing more psychiatric information for every physician, no matter what his specialty, WTVS, Detroit educational television station, recently presented a 10-week series of programs under the general title of Psychiatry in Medicine. They were planned by the psychiatry department of the Wayne State University College of Medicine in cooperation with the psychiatry department of the Detroit Receiving Hospital.

Among the topics were depression, the

suicidal patient, the psychology of convalescence, emotional problems of children, psychiatric emergencies, alcoholism and drug addiction.

* * *

Since February 1959, when the American Board of Psychiatry and Neurology was authorized to undertake certification in child psychiatry, six physicians have been certified in the sub-specialty. All are diplomates in general psychiatry. They are Dr. Frederick H. Allen, Philadelphia; Dr. Frank J. Curran and Dr. William S. Langford, New York; Dr. Othilda Krug, Cincinnati; Dr. Hyman S. Lippman, St. Paul and Dr. Joseph Franklin Robinson, Wilkes-Barre.

* * *

Growing interest in psychiatry in the medical profession itself is reflected in a statistic from the University of Washington. Nine of last year's medical class of 70 plan to specialize in psychiatry—a far higher percentage than in the past.

* * *

In an attempt to attract college students to careers in mental health, the Kentucky Department of Mental Health placed ads this spring in 13 college newspapers. The ads called attention to stipends offered by the department to graduate students interested in becoming psychiatric social workers, psychologists and occupational therapists. They were scheduled in 6 college papers in Kentucky, 3 in Mississippi, 2 in Tennessee, 1 in Florida and 1 in Indiana.

"The response has been gratifying," Commissioner H. L. McPheeters reports. "We feel we've found a good way of publicizing our efforts to train more mental health workers."

APPOINTMENTS

Dr. Harvey J. Tompkins has been elected president of the Academy of Religion and Mental Health. He is director of psychiatry for St. Vincent's Hospital, New York City.

The academy is a national educational and research organization with headquarters in New York. It endeavors to integrate the moral values of religion and the scientific insights of psychiatry and the behavioral sciences.

* * *

Dr. Eli Ginzberg, Columbia University economics professor, and Dr. John C. Whitehorn, director of the psychiatry department at the Johns Hopkins University School of Medicine, have been appointed to the National Advisory Mental Health Council for 4-year terms. The council advises Surgeon General Leroy E. Burney of the U. S. Public Health Service on programs of the National Institute of Mental Health.

* * *

Dr. Arthur P. Noyes, internationally known psychiatrist, resigned from his post as superintendent of Norristown, Pa., State Hospital on June 12 but remains in state service in a newly created position as director of professional education and consultant to the Commissioner of Mental Health.

In the 23 years Dr. Noyes was at Norristown, his reputation and teaching skills were responsible for attracting many young psychiatrists to state service. In his new post he is responsible for coordinating psychiatric residency programs, with particular emphasis on the development of a training program in mental hospital administration.

Dr. Noyes, who is 79, is a past president of the American Psychiatric Association, and the author of several well-known text books in psychiatry.

AWARDS

The Veterans Administration Chief Medical Director's Commendation, highest award

given by the VA Department of Medicine and Surgery, has been presented to Dr. Erwin W. Straus of the agency's Lexington, Ky., hospital.

Dr. Straus was cited for his outstanding contributions to the VA patient care and medical research programs and for his contribution to psychiatry through his writings, lectures and exhibits.

As director of the research and education service of the Lexington hospital, he has worked closely with the VA's large-scale cooperative studies of chemotherapy in psychiatry since these were begun in 1954. He is also engaged in extensive research of his own, studying expressions, gait, gestures and other behavior of mentally ill patients.

• • •

Dr. Alvin I. Goldfarb, a pioneer in psychotherapy for the aged, was honored last May by the retired members of District 65, Retail, Wholesale and Department Store Union, ALF-CIO.

He was cited for "re-examining old ideas and developing new theories by exploring with new techniques ways of bringing relief and hope to the mentally ill older patient. As a result of his work thousands today can remain in their communities or in homes for the aged instead of having to be sent to mental hospitals, where the door frequently closes forever."

Dr. Goldfarb is director of psychiatric and neurological services at the Home for Aged and Infirm Hebrews and special consultant on aging to the New York State Department of Mental Health.

Dr. George S. Stevenson, editor of MENTAL HYGIENE and consultant to the National Association for Mental Health, received a similar award from District 65 a few years ago.

MEETINGS

Physicians, psychiatrists, legislators and members of the Southern Regional Education Board meet in Atlanta October 8–9 to discuss methods of supplying information about psychiatric principles to physicians who are not psychiatrists.

Attending the region-wide conference are representatives from state medical associations, academies of general practice, psychiatric associations and medical schools, along with key legislators and physicians and psychiatrists in private practice.

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Although facilities, regulations and methods for the care of the mentally ill may differ from country to country, participants in a recent World Health Organization conference in Helsinki unanimously agreed on the aims of mental health services:

- Better treatment inside and outside hospitals with more patients being cured more rapidly.
- Better educational facilities for handicapped children so as to prevent their becoming institutionalized cases.
- Earlier detection of mental illness, through medical services and general practitioners, but also through teachers, social workers, judges and police officers.
- Reduction of stress in the environment as a means of prevention, especially in the institutions for children and the old.
- Increased understanding of mental health problems by the public, the public authorities and health workers generally and increased tolerance in society for odd behavior.
- More research.

About 60 psychiatrists, general practitioners, nurses, social workers and psychologists from 26 European countries attended the conference. It was convened to determine the general principles of mental hy-

giene applicable in all the countries of Europe. Prof. Arie Querido of Amsterdam was chairman.

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The second annual meeting of the Society for the Scientific Study of Sex is set for November 7, in the Barbizon Plaza Hotel, New York City. The program consists of two symposia, one on the psychological factors in infertility, the other on the question of what is sexually normal.

Further information is available from Robert V. Sherwin, Suite 704, 1 E. 42nd St., New York 17.

* * *

Thirty-five western leaders in mental health attended the second annual meeting of the Mental Health Council of the Western Interstate Council on Higher Education in San Francisco, June 18–20.

Two administrators from the Langley Porter Neuropsychiatric Institute — Dr. Alexander Simon, medical superintendent, and Dr. Klaus Berblinger, chief of clinical services—described a new joint WICHE-Langley Porter program of postgraduate psychiatric education for western physicians. Under the direction of Dr. Berblinger and Dr. Warren Vaughan, WICHE's new mental health project director, a 10-week series of seminars will be given to groups of local physicians in general practice, pediatricians, internists and surgeons. Each seminar group will meet once a week and will stress the typical psychiatric problems encountered in a physician's practice.

During the first year of the program, teaching units will be set up in four western cities. The faculty of each unit will consist of two qualified psychiatrists approved by local medical societies. All of the psychiatric teachers will attend an intensive two-day institute at Langley Porter.

The Mental Health Council also:

1. Created a committee to plan a program of mental health traineeships.

2. Approved a proposal to set up machinery for a western advisory service in mental health research.

3. Endorsed a regional training and research program in the field of mental retardation.

4. Approved plans for a conference on in-service training for directors of psychiatric nursing services.

5. Approved a proposal for a multi-disciplinary conference of the directors of university training programs in psychiatry, social work, psychology and nursing.

6. Recommended that the WICHE mental health newsletter be continued on a regular basis.

7. Appointed former Governor Milward Simpson and Dr. Herbert Gaskill to consider the possible application of the Western Interstate Corrections Compact to methods of dealing with the mentally ill.

Albert Deutsch, well-known writer and mental health expert, was the principal speaker at the council meeting. Speaking on "New Directions in Mental Health Research," Mr. Deutsch deplored the growing tendency to look to the federal government as the dominant source of financing mental health research. He contended that "the states and localities, along with appropriate voluntary agencies and foundations in the field, cannot evade their own responsibilities for developing and supporting more research effort. Even if the federal government could finance the entire field, it would be dangerous to independent scientific investigation to allow one source to dominate it. We need cooperation, but we need friendly competition, too."

* * *

Psychiatric problems of the aging, including those who are mentally defective, will

be the main topic of the American Psychiatric Association's 11th mental hospital institute. It will be held October 19–22 in Buffalo.

The principal speaker will be Rep. John E. Fogarty, chairman of the House of Representatives' subcommittee on labor, health, education and welfare. His address is titled "Economics, Ethics and Mental Illness."

A special feature of the final session will be a question period called "Hospital Psychiatry Meets the Press." Newspapermen and hospital psychiatrists will query each other along two general lines: "The Press —Help or Hindrance in Fighting Mental Illness?" and "Are We Making Progress Against Mental Illness?"

The institutes are held annually by APA to give U. S. and Canadian mental hospital workers a chance to talk over common problems.

* * *

Methods of streamlining the reporting of mental health statistics to facilitate research were discussed recently by statisticians and key mental health officials from 16 southern states and the National Institute of Mental Health. The region-wide conference, held in Atlanta, was sponsored by the Southern Regional Education Board's mental health program.

"This is the first time mental health statisticians from all southern states have had an opportunity to compare notes on how data is collected in each state," Dr. Harold McPheeters, Kentucky mental health commissioner and conference chairman, pointed out. "This meeting gave them a chance to exchange information about ways of making facts and figures uniform so that reports of one state will be comparable with those of another."

According to Dr. Wm. P. Hurder, SREB associate director for mental health, there are two main advantages to a unified mental health accounting system: (1) it makes it easier for administrators to compare their operations with those of other states and (2) it opens up new research possibilities for administrators and researchers.

At the present time the reported cost of patient care, for example, varies with almost every state since statutes defining elements of the budget vary from state to state. Cost per patient per day often reflects such variable items as whether or not clothing is furnished to patients or room and board are provided for personnel. These figures therefore are not an accurate index to the amount of money spent for care and treatment of patients in different states, Dr. Hurder explained.

As one method of unifying reporting procedures, participants discussed the Model Reporting Area—a cooperative effort among states and the National Institute of Mental Health in reporting mental statistics. Of the 21 states in the nation in the Model Reporting Area, 7 are in the southern region. Other southern states are now making plans to join MRA.

A committee was appointed to work further with the SREB to investigate methods of coordinating the reporting of statistics in the South. Mr. Cecil R. Wurster, chief of research for the Louisiana Department of Hospitals, was elected chairman by the group.

* * *

The American Psychosomatic Society will hold its 17th annual meeting at the Sheraton-Mt. Royal Hotel in Montreal, March 26–27, 1960.

The program committee would like to receive titles and abstracts of papers for consideration for the program no later than December 1, 1959. The time allotted for presentation of each paper will be 10 or

20 minutes. Abstracts of two or three pages, in nine copies, should be submitted for the committee's consideration to Dr. Eric D. Wittkower, chairman, 265 Nassau Road, Roosevelt, N. Y.

* * *

The mental health commissioners of 34 states have formed the National Association of State Mental Health Program Directors. They plan to incorporate as a nonprofit organization in the District of Columbia and to hold their first annual meeting October 19 in Buffalo during the 11th Mental Hospital Institute.

The officers, elected April 29 in Philadelphia, are Dr. George Jackson of Kansas, president; Dr. Clifton T. Perkins of Maryland, vice-president, and Dr. Harold McPheeters of Kentucky, secretary-treasurer. Three were elected to the executive committee: Dr. J. B. K. Smith of Alaska, Dr. V. Terrell Davis of New Jersey and Dr. Dale C. Cameron of Minnesota.

PUBLICATIONS

The continued decline in the number of patients resident in mental hospitals is spelled out in Fact Sheet #9 of the Joint Information Service co-sponsored by the National Association for Mental Health and the American Psychiatric Association. At the end of fiscal 1957, a total of 787,525 patients were in mental hospitals. During the year, 514,134 had been admitted, 450,156 discharged.

Copies of the Fact Sheet are available from NAMH, 10 Columbus Circle, New York 19.

* * *

The Society for the Scientific Study of Sex will publish a new periodical, *The Journal of Sexual Research*. The first issue will appear early in 1960.

The journal is to include original articles, reviews of the literature, book reviews and abstracts covering the range of all the learned disciplines pertinent to the study of sex. Papers should be submitted to Dr. Hugo G. Beigel, 138 E. 94th St., New York 28.

* * *

Volume 1, Number 1 of the *Archives of Neurology* appeared in July. The new journal is published monthly by the American Medical Association, with Dr. Harold G. Wolff of New York as chief editor.

Its primary aim, according to the first editorial, "is to further knowledge of clinical neurology, and thus to advance neurological science in general."

Manuscripts that make genuine contributions to the understanding of clinical phenomena, including diagnosis, etiology, symptoms, signs and treatment, and of the factors that modify their course are to be given high priority, according to Dr. Wolff. Also included in this category are manuscripts that deal with the setting in which disease occurs.

"Insofar as manuscripts describing neuropathological material, or chemical, physiological, neurosurgical, electroencephalographic or psychological studies clearly illuminate neurological clinical states, they will be given preference," Dr. Wolff writes.

Subscription rates for the new periodical are $14, domestic; $14.50, Canadian; $15.50, all other countries; $8, students, interns and residents in the U. S. and its possessions.

* * *

The national mental health survey conducted the last three years by the Joint Commission on Mental Illness and Health was officially terminated June 30, 1959. The commission's findings and recommendations for a national mental health program will be set out in a series of 10 monographs and a final report.

Three monographs have already been published—on concepts of positive mental health, the economics of mental illness and the recruitment of psychiatric manpower. Others, to be published within the next few months, will be titled *Americans View Their Mental Health: A Nationwide Opinion Survey, The Role of Schools in Mental Health, Research Resources in Mental Health, Religion in Mental Health, Community Resources in Mental Health, Epidemiology of Mental Illness* and *The Mental Patient and His Care.*

For the final stages of its work, the commission has moved to offices at 74 Fenwood Road, Boston 15.

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Information for applicants for certification in child psychiatry has been published by the American Board of Psychiatry and Neurology and is available in pamphlet form from the secretary, Dr. David A. Boyd, Jr., 102–110 Second Ave., S.W., Rochester, Minn.

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A survey of salaries for professional positions in psychiatric clinics and hospitals in 1958 has been completed by the Des Moines Child Guidance Center.

The study, based on a nation-wide sample, describes salary levels and ranges in relation to the training and experience required for each type of job. It compares salaries in 1958 with those reported in a similar study made by the center in 1955.

Copies of the current study are available at cost (single copy, 25¢; 10 or more, 15¢ each) from the Des Moines Child Guidance Center, 500 Garver Building, Des Moines 9, Iowa.

• • •

The first number of a new psychiatric periodical, *Journal of Neuropsychiatry,* was to appear in September 1959. It will reiterate the purpose of the American Society of Medical Psychiatry:

- To promote study of the disorders of the function of the brain called mind and to promote its healing.
- To promote study of the effects of pharmacological, biological, immunological and other physical agents on the human brain.
- To further study of treatments of neurological, psychiatric and allied diseases.
- To stimulate and encourage research and training among members of the medical profession.

Dr. L. J. Meduna, Chicago, will serve as editor-in-chief. Dr. A. I. Jackman, Chicago, and Dr. A. A. LaVerne, New York, will be the editors. The advisory board of international experts includes Dr. Juan F. López Ibor, Madrid; Dr. Gabriel Langfeldt, Oslo; Dr. A. C. Pacheco e Silva, São Paulo; Dr. Hans Hoff, Vienna; Dr. Francis J. Gerty, Dr. Frederick A. Gibbs and Dr. Leo A. Abood, all of Chicago.

During its first years the journal will be published bimonthly. The annual subscription fee has been set at $10 for the six issues.

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The realities of the mental health manpower shortage are the subject of a study released in June by the Joint Commission on Mental Illness and Health.

The study comes to the conclusion that sufficient professional personnel to eliminate the glaring deficiencies in public care of mental patients will never be available if the U. S. population continues to grow without a parallel increase in the recruitment and training of mental health manpower.

Only a great change in social attitudes and a consequent massive emphasis on education or a sharp breakthrough in research on mental illness will change this negative outlook, according to the study.

Most of the 350-page report, titled *Mental Health Manpower,* is devoted to an analysis of the causes of the shortage of psychiatrists, psychologists, psychiatric nurses and psychiatric social workers needed to provide first-class treatment for the mentally ill.

The study was written by Dr. George W. Albee, Western Reserve University psychology professor. It was published by Basic Books (59 Fourth Ave., New York 3), and is available from the publisher or from book dealers for $6.75.

* * *

Miss Dorothy Donaldson, editor of *Recreation Magazine,* has announced that two pages have been added to the publication, to be used only for notes on recreation therapy for the ill and handicapped. Those interested in this field are invited to contribute.

* * *

Recent community mental health laws are reviewed in a new publication of the Joint Information Service co-sponsored by the National Association for Mental Health and the American Psychiatric Association.

Most of these laws embody four significant principles, the study shows:

- They are permissive rather than mandatory.
- They provide for comprehensive, well-rounded local mental health programs under a local board, with the state providing advisory service.
- They put the responsibility for the program on the community and make the director responsible to the community rather than to the state.
- And they make the state responsible for up to one-half the cost of the program if certain standards are met and certain procedures are followed.

The study analyzes in some detail the community mental health laws of New York, California, Minnesota and New Jersey, and briefly discusses those of Vermont, Indiana and Tennessee.

Several questions have arisen in administering the laws, the Joint Information Service points out. How do you define a mental health service? Shall preventive as well as treatment programs be included? How should responsibilties be divided among state government, local government and voluntary agencies? Should psychiatric care of the aged be included? What should be the relationship between community mental health programs on the one hand and community activities carried on by state mental hospitals on the other? What should be the relationship of the community mental health program to organized medicine and the private practice of psychiatry? And finally, where do you get enough professional personnel to man new community mental health facilities?

A bibliography is included in the study.

Copies of the fact sheet (No. 8) are available from the National Association for Mental Health, 10 Columbus Circle, New York 19.

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The national mental health survey conducted by the Joint Commission on Mental Illness and Health the last three years officially terminated June 30, 1959. Its findings and recommendations for a national mental health program will be set out in a series of 10 monographs and a final report:

- *Current Concepts of Positive Mental Health,* by Marie Jahoda (Basic Books, 1958, $2.75). This monograph has had an excellent reception since its publication

last fall. It has helped clear the air on what is meant by "mental health." Approximately 6,000 copies have been distributed.

• *Economics of Mental Illness,* by Rashi Fein (Basic Books, 1958, $3). This likewise has been well reviewed and generally acclaimed as a valuable contribution to the understanding of costs. Approximately 3,000 copies have been distributed.

• *Mental Health Manpower Trends,* by George W. Albee. Basic Books released this monograph, the first product of the commission's larger study projects, in June 1959. It is expected to command a great deal of attention.

• *Americans View Their Mental Health; A Nationwide Opinion Survey,* by Gerald Gurin, Joseph Veroff and Sheila Feld, Survey Research Center. This much-anticipated study of what people say troubles them and what they do about their troubles should be available in the fall.

• *The Role of Schools in Mental Health,* by Wesley Allinsmith and George W. Goethals. This study, carried out at the Harvard University Graduate School of Education, will be published in the fall.

• *Research Resources in Mental Health,* by William F. Soskin. This will be published in the early winter.

• *Religion in Mental Health,* by Richard V. McCann. This provocative study, conducted under a grant from the Rockefeller Brothers Fund, will also be published in the fall.

• *Community Resources in Mental Health,* Reginald Robinson, David F. DeMarche and Mildred K. Wagle. This will be published in late fall.

• *Epidemiology of Mental Illness,* by Richard J. Plunkett and John E. Gordon.

• *The Mental Patient and His Care,* by Morris S. Schwartz, Charlotte Green Schwartz, Mark G. Field, Elliot G. Mishler, Simon S. Olshansky, Jesse R. Pitts, Rhona Rapoport and Warren T. Vaughan, Jr. This monograph, covering not only the care of hospital patients but outpatients and ex-patients, will be published in the winter.

• *The Final Report.* It appears quite probable this will be published simultaneously with Monograph 10, *The Mental Patient and His Care.*

MISCELLANEOUS

One of the most unusual collections of paintings in the nation now hangs in the national headquarters of the American Psychiatric Association in Washington, D. C.

The 24 paintings are the work of psychiatric patients in art therapy clinics of Veterans Administration hospitals. They were chosen by James McLaughlin, curator of the Phillips Gallery in Washington. Most are of outstanding quality as art, he said.

Mostly oils and watercolors, the paintings range in subject matter from a portrait of President Eisenhower to still life of flowers and fruit, outdoor scenes, and abstractions. They were selected from VA hospitals in Montrose, N.Y., Palo Alto, Calif., Perry Point, Md., and Topeka, Kan.

* * *

In May 1956 the presidents of all state psychological associations were asked to appoint a liaison representative to the American Psychological Association's committee on mental health programs to fill

out a questionnaire on the activities of psychologists in community mental health services. In states where there was no association, a leading psychologist was contacted.

Each liaison representative was asked 6 questions:

- To what extent do psychologists participate in community mental health activities?
- To what extent has the state or local psychological association evidenced interest in community mental health activities?
- To what extent is the climate of the community or state favorable or unfavorable to the participation of psychologists?
- To what extent are psychologists themselves interested in participating in community mental health problems?
- Could you list for us some examples of activity in the state involving psychologists? Could you also take note of some psychologists whom you feel are particularly active and successful in this area?
- What are your suggestions for the operation of the committee on a national scale and also on a state and local community level?

The responses concerning the degree of involvement were rated on a 5-point scale: very extensively, extensively, moderately, poorly, hardly at all. Attitudes were rated as very favorable, favorable, neutral, unfavorable and antagonistic.

On the basis of 43 reports, Arthur J. Bindman of the Massachusetts Department of Mental Health, committee chairman, and Theodore Landsman of the University of Florida, have summarized the findings as follows:

"On a nation-wide basis, individual psychologists are involved fairly extensively in local community mental health activities. They appear to be well accepted by both lay and professional persons. In general, this type of activity is considered to be respectable.

"On the other hand, state psychologist associations show almost no interest in mental health activities in their communities. There appears to be a dichotomy between those areas where universities sponsor these interests and those where barriers of an 'ivory tower' nature intervene.

"There are also many suggestions that APA play a stronger role in interesting and influencing local and state psychological associations to take part in community health activities, as well as to publicize more widely the important role of psychologists in community mental health practice."

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a coordinated citizens organization working toward the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.